children

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS

AN

NOW
once
future
his pa

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

children

®

VOLUME 6

NUMBER 1

JANUARY–FEBRUARY 1959

NOW AN URBANITE this child of New York's streets once lived in a rural section of Puerto Rico. What his future holds will depend a great deal on the ability of his parents to give him a warm family life in spite of the shocks and confusions they face in adjusting to the city's pace and cultural expectations. The effects on family life of this and other types of change taking place today are discussed in the lead article in this issue.

Before taking his present position 2 years ago, Gunnar Dybwad was for 6 years director of the Child Study Association in New York. Previously he served for 8 years as director of child welfare for the State of Michigan. In 1949 and again in 1950 he went to Germany as a child-welfare consultant, first for the Secretary of the Army and then for the Department of State. He is a graduate of the New York School of Social Work.

Before joining the Children's Bureau staff 2 years ago, Mortimer Garrison was chief psychologist at the Training School at Vineland, N. J., a private school for the mentally retarded. Previously he was assistant professor of psychology at the University of Pennsylvania. He received his doctoral degree from Columbia University.

William G. Hardy (left) and Miriam B. Pauls (right) have been associated in their work for children with communicative disorders for the past 10 years. They are respectively associate and assistant professors of otolaryngology at the Johns Hopkins schools of medicine and public health.

Myrtle Wolff began her professional career as rural child-welfare worker in Illinois. Before going to her present position in North Carolina in 1954, she was for 13 years with the Illinois Department of Public Welfare in a variety of capacities—child-welfare consultant, child-welfare supervisor, regional representative, administrative assistant, superintendent of the girls' training school. She is a graduate of Chicago's School of Social Service Administration.

In the summer of 1957 Eleanor S. Wertheim took a 1½ year leave of absence from her position in Australia to go to the United States and Europe to study and observe recent developments in child guidance, psychiatry, and research. She spent a year as a Fulbright grantee studying at the Graduate School of Psychology, University of Michigan and working at the Hawthorn Center in Northville. She was educated at the Sorbonne in Paris and at the University of Melbourne.

For 5 years, 1952–57, Donald W. Jackson, as executive of the Valley Children's Services and its predecessor the Valley Boys' Ranch in Harlingen, Tex., stimulated and participated in the changes his article describes. A psychologist with training in social work, he was for a year assistant director of the Texas Youth Council before becoming director of the Corsicana State Home for dependent children.

◀ *the authors*

How rapid trends toward industrialization and urbanization are affecting . . .

FAMILY LIFE IN A CHANGING WORLD

GUNNAR DYBWAD, J. D.
Executive Director, National Association for Retarded Children.

IN RECENT YEARS the family has become the subject of much controversy. Certain sociologists have for the past several decades been writing it off as a doomed institution, while others regard it as the bulwark around which human existence can forever reorient itself for new tasks and challenges. What actually is happening to family life and parent-child relationships in this churning cauldron of change that is the world today?

No one can have enough information to assess the conditions of family life in all the world today. But it is possible to sketch broadly some of the implications of those two complementary trends, industrialization and urbanization, on the family as an institution, on its members, and finally on its supporting services.

Two years ago the Eighth International Conference of Social Work devoted its entire time to a consideration of industrialization. Perhaps the broadest and most significant finding of that international gathering was the realization that industrialization was moving ahead steadily and relentlessly, leaving no part of the globe untouched.[1]

Wherever industrialization develops, it inevitably deeply influences existing family life. For one thing, it rearranges time-honored work processes: what was once hard labor requiring the efforts of several men becomes an easy operation that even a child can handle. What once had to be obtained far away from the home now is available in the home. Conversely, work that formerly was done in the home now is performed a long distance away, sometimes requiring separation of the family, or, in other instances, is done at home in a new type of sweatshop which requires members of a family to work in shifts around the clock.

Urbanization

Urbanization invariably follows industrialization. A United Nations conference on the mental-health aspects of urbanization, sponsored by the World Federation for Mental Health in 1957, noted a sequence of "industrialization—urbanization—mental-health problems," the last being largely related to the family and its functioning in a new social situation.

There, too, it was reported that a very frequent, though not universal, aspect of urbanization was the disappearance of the large *extended* family in favor of the small, *nuclear* family of parents and children, a family more vulnerable to emergencies, and generally lacking the framework for a close relationship between the generations.[2] This change from the extended to the nuclear family has accentuated the worldwide housing shortage.[3]

Moreover, there is today in many parts of the world no longer any clear-cut line of demarcation between urban and rural areas: in addition to a vast increase of suburban localities independent of the cities they adjoin, there are large developments in rural areas which have at least some distinctly urban characteristics. While these developments proceed

Based on a paper presented at the World Child Welfare Congress, Brussels, July 1958.

differently in different places, the prediction is that within four decades, one quarter of all the people of the world will live in cities of 100,000 people or more.[4]

The task ahead is clear. This is to find ways of developing industrialization and urbanization that will strengthen rather than weaken family life—to channel the new forces to safeguard essential cultural aspects of the peoples affected. This presupposes a realistic facing of the future rather than an attempt to stop the clock.

Migration

An inevitable by-product of industrialization and urbanization is *migration*. Just as the last of the nomadic peoples begin to develop permanent settlements, the rest of mankind seems bent on moving about in search of greater economic rewards. This brings the family the disadvantage of "uprootedness," the danger of being "lost" in a new location, the separation from cultural traditions and their inherent moral support.

Another disturbing result of movement is the absentee father, whose work takes him away from his family for weeks or months at a time, or for so many hours during the week that he becomes merely "an overnight boarder" in his own home. Of course, this phenomenon is not entirely new but it has never been considered a constructive one for the family, and it is becoming more and more common. Julia Henderson has pointed out that this calls for concern about the father's existence as well as the family's he leaves behind: If the separation is one that extends over weeks and months then a new problem may arise from sexual relationships he may form at his place of work, resulting in additional "family" responsibilities.[2]

Problems of migration affect all income groups. In India, for instance, mobility is particularly prevalent among the lower economic groups in their search for better jobs and wages, while the upper income groups tend to stay on the land they own. In the United States, on the other hand, in recent years administrative and technical employees of large corporations especially have been required to move their families from place to place.

All these developments have brought to families feelings of confusion and insecurity. As old cultural patterns prove inadequate to modern needs, as migration brings families in contact with new customs and ways of life, as the greater flexibility of young people allows children to adjust to new situations more speedily than their elders, parents become puzzled and bewildered. Through newspapers, picture journals, films, radio, and television, children pick up quickly, if somewhat superficially, more general information than individuals in former generations could gather in a lifetime.

Perhaps the factor making the greatest impact on family life today is the sheer pace of technical progress. Until a few decades ago, the ever-changing ways of living proceeded slowly enough to permit a gradual transition from one generation to the next. Parents could form a fairly accurate picture of the circumstances under which their children would live and could guide them accordingly. Today parents find increasing difficulties in adjusting to the fact that the younger generation often has knowledge, skills, and global orientations which they the parents do not adequately comprehend. Still somehow aware of their age-old role as bearers of cultural traditions, they feel a growing uncertainty as to how far they can impose their own standards on children who are destined to live in a world they cannot visualize.[5]

This does not mean that parents have abdicated their responsibilities. Undoubtedly, most parents still are as concerned as ever with their children's welfare, but they wonder how they can lead when they sense so much their own need for direction. Industrialization and urbanization are less threatening to the family as an institution than to the traditional structure within the family. In some instances this has led to exaggerated exhortations to parents to reinstitute authoritarian patterns of family hierarchy and family discipline.

Individuals and Roles

In considering the effects of industrialization and urbanization on the family's members, one must be ever mindful of the need for social policies to focus on serving and improving conditions for the family group as a whole. In the past some of us have concentrated too much on what we thought was helpful to the child and not enough on what was appropriate to the child *as a member of his family*. As a matter of fact even this focus is not broad enough, for we must also think in a larger dimension of the family's place in the community.

Nevertheless, it is also important to look at family structure in terms of intrafamily relationships—parent-child, husband-wife, brother-sister—and of the parent or the child as an individual in his own right.

It is the individual who can and must make the most important contribution toward the improvement of social conditions.

The emphasis on the individual as a human being in his own right as well as a member of the family unit seems particularly important in this day of mass movements, mass housing, mass media of communication, mass employment, and mass education. Indeed, with the rapid increase in urbanization we should expect a greater emphasis on the individual since one of the strange contradictions about urban development is that while, on the one hand, it submerges the individual and his family in a mass, it at the same time affords each person a greater opportunity to establish social status away from his family.

This calls for consideration of the concept of role, developed by the sociologists. According to this concept, each individual can be regarded as holding a status to which are attached certain rights and duties. As he puts these into effect he performs his "role." In this area of role performance considerable controversy exists regarding present-day practices in family life and parent-child relationships. The focus of this controversy is on the question as to whether recent developments have tended to blur the appropriate roles of the male and female members of the family, thus endangering the effectiveness of parent-child relationships by creating confusion in the mind of the child and of the parent as well.

The psychoanalyst Bruno Bettelheim has developed this thesis in an article entitled "Fathers Shouldn't Try To Be Mothers."[6] But then the question arises: what does a father do and what does a mother do? For some people the answer is easy: the father acts out and thereby interprets the role of a male; the mother, the role of the female. Yet, this provokes the further query: what is male and what is female?

Many attempts have been made to answer this most basic question. Morris Zelditch, Jr.,[7] for instance, presents a thesis which can be summarized thus: In the social system that evolves within the nuclear family two basic roles can be differentiated, instrumental leadership and expressive leadership. Instrumental leadership, which involves primarily a manipulation of the external environment and consequently a good deal of physical mobility, is performed by the father, while the expressive leader is the mother, the family's source of security and comfort.

That there are universal aspects of male and female roles is an unassailable contention of contemporary anthropological research. However, the problem is how far beyond the obvious physiological factors there is any sure ground for claiming basic and universal characteristics. Still more pertinent, however, is the question: To what extent is so definitive an assignment of general roles to the male and female really feasible? Does not science's growing knowledge about other aspects of the human being indicate that such clear lines of demarcation as once were drawn, for instance, between physiological and psychological aspects are becoming less and less distinguishable?

We should be greatly concerned over the far-fetched conclusions which have been drawn from the basic differences between the sexes in regard to the appropriate role of men and women, and more specifically, fathers and mothers. We must face this question squarely and find an orientation which seems appropriate to our era, or else we will not be in a position to plan intelligently for our children and their families and to develop the supporting services they need.

Changing Role Functions

The first way in which many critics of new family developments see violence being done to basic laws of nature is through the work activities of men and women in and about the home. They see life as it was when the man protected the family from enemies and hostile beasts, went out hunting, and plowed the ground, while the woman stayed at home nursing the baby, weaving and sewing, and taking care of their abode. For instance, a distinguished psychiatrist has maintained that it is important for boys to learn that man's role is "to aggressively defend the home."[8]

Actually, of course, industrialization and urbanization frequently remove the man far from the home, leaving the woman or the organized authorities to defend it. Men no longer need to carry arms in countries where industrialization has taken hold. Today physical strength and endurance are measured in many ways. In the United States, statistics show that there the women are the stronger sex, if longevity is a criterion. Moreover, many women are physically more active around the house and do more walking and lifting than their husbands do in the office or at a machine in the factory.

What about the other function of the male, as provider, supplier, or wage earner? Certainly all over

One of the thousands of families in the world today who have recently changed from rural to urban living this American family considerably improved its living standards when the father got a job in industry. Their move from a poverty stricken Indian reservation was accomplished with the help of the Department of the Interior's Bureau of Indian Affairs.

the world men are still predominantly fulfilling these functions. However, today they are not alone in this. Increasingly women, too, are breadwinners, at least for certain periods of their lives. As industrialization and mechanization progress, specific jobs which were formerly the prerogative and indeed one of the distinctions of a man are now held competently and comfortably by women as well. Work outside the home is no longer a distinguishing characteristic of the male.

Actually, one of the consequences of industrialization and the breakdown of the extended family system is that many women are forced to work outside the home just to provide a minimum means of subsistence for the family. However, as urbanization and mechanization progress many women take a job because they seek a fuller life outside the home or because they want to earn money to buy some of the mechanical household equipment which industrialization brings to them. Whether or not a mother *should* work outside the home is a matter of judgment which does not fit into this particular discussion of male and female roles.

The third characteristic of the male role as conceived by some sociologists is of the male as the manipulator of the outside world, the person who participates in public affairs, who represents the family group outside the home. That this is likewise a distinction which is losing its validity is amply attested by the tremendous contributions women all over the world are making to the improvement of public life and community services.

It is important in considering the effect, up to now, of industrialization and related socioeconomic changes in the family and in contemplating future supportive steps on behalf of the family to question seriously those who insist on the maintenance of traditional general patterns of male and female functioning. On the one hand, we should be ready to accept the fact that the radical changes of industrialization, urbanization, and mechanization will a the same time limit and broaden the activity base of both men and women. On the other hand, we should be mindful that social and economic progress, well-directed, can bring forth increasing opportunity for individual expression. It need not be a sign of decay that the concepts of sex roles are less distinct. To the contrary, this should provide broader opportunities for the men and women in the family group to unfold their individual human potentialities.

Those of us concerned with the welfare of children should be more and more concerned with the increasing problems young people face as they contemplate marriage today. Marriage, of course, has always been a serious undertaking, but in former days the support of the large extended family group, the continuing counsel of mother and mother-in-law, the example of other young couples, and finally the existence of clear-cut patterns of conduct and activities expected of men and women provided guidance and helping hands for the young couple. In the industrialized and urbanized society however, which moves away from rigid role patterns and at the same time separates the young couple from the larger family group, more demands are made on bride and groom.

Therefore, it is a cause for concern that at a time when child marriages are on the wane in Eastern countries, in certain highly industrialized Western countries they are being contracted at an increasingly younger age.

Today's New Families

Furthermore. "romantic love" as a basis for marriage is spreading throughout the world. This derives from greater independence of young men and women from their families and more informality or lack of ceremonial custom is choosing the marriage partner. The corollary of this independence is in-

creasing separation or even actual isolation of the new young family from either or both of the parent families.

Western countries, in particular, have been experiencing increases in divorce rates. This would seem to call for more attention and service at the point of engagement and marriage to help the developing new patterns become channeled in constructive lines. Unfortunately, there are too few opportunities where young people about to be married can get this type of counseling. Of course the development of maturity should be nurtured long before the point of marriage, all through the days of education at home and at school.

With all their problems most young couples today, as always, eventually assume parental responsibility. Here again professional controversy has arisen as to proper roles. There is a thesis that early child development involves a "symbiosis," a physiological as well as psychological living together of the mother and her infant child for many months after birth, centering on the mother's nursing of the child; and that in this relationship the father can only be an intruder. Some distinguished authorities go so far as to say that during his first 6 months, or even his first 2 years, a child should be in the exclusive care of his mother.[9]

This viewpoint gained considerable strength about 10 years ago after some reports on the relationship between mothers and infants in certain primitive societies were published. However, Margaret Mead, one of the foremost students of primitive culture, insists that insights gained from studies of primitive people must be applied in forms appropriate for modern industrial society and warns against taking as a model for our current urban society the primitive mother who delivers without help and breast feeds easily. She warns against allowing overemphasis on the ancient biological responses of lactation to obscure the appropriate tasks of the 20th-century parents. Experience in some eastern societies, she reports, has shown that this close and exclusive tie between mother and infant results not only in a comfortable sense of security, but also in a fear of, and inability to meet, strangers—a response appropriate in a past culture, but no longer appropriate today.[10]

There is of course a most meaningful relationship between the mother and her infant child, but it seems likely that instead of losing its value, it is actually enhanced when it includes others, particularly the father and other children in the family.

Infant care has been the subject of controversy in another direction also. Some critics hold that it is an effeminate affectation for fathers to become involved in the physical care of their infants, helping to clean them, feed them, and put them to sleep. They see in such fathers a particularly serious confusion of role conduct which will result in retarding or preventing the infant's image of the father as the strong, aggressive leader, and thereby interfere with the development of a sound family structure.

The research available in the area of infant care is overwhelmingly based on investigations of mother-child relationship. However, it should be stressed that we have at least the beginnings of research on the effect of father deprivation on infants, and that these preliminary results would support the thesis that infants need contact with their fathers as well as with their mothers.

Here again it is important to emphasize the necessity of recognizing individual differences. Not all fathers find pleasure in taking care of the physical needs of their infants; but neither do all mothers find pleasure in such tasks, though the great majority do, no doubt. No one suggests that *all* fathers *should* take turns with their wives in caring for infant children, but certainly more good than harm seems likely to result from tangible, direct relationship between infant and father from the very beginning of the child's life. Indeed, in some countries efforts are made to help the expectant father to understand the process of pregnancy so that this will be a period of sharing with his wife rather than a period of increasing separation. Undoubtedly, many people will have difficulty in accepting this view, because for too long we have allowed the lives of individuals as well as nations to be governed by principles of an authoritarianism which depended on the father figure as its particular symbol.

New Patterns Needed

Authoritarianism still manifests itself in patterns of family life in most countries of the world, including the United States. This fact should force persons in child-welfare work to move beyond their own particular functions into the market place of public opinion to share their knowledge and insights with others. Time is running out on us. What kind of concept do we want our children to have of man's family and the family of man?

Ten years ago, Brock Chisholm said:

> It is quite clear that we must learn to live in peace with each other throughout the world. If we do not do so, there is

little prospect that our children will finish their lives according to the statistical probabilities on which the life insurance companies depend . . . .

It is well worth our while to look at the way we were brought up, the way we were developed, and hope to find out what is wrong with us so that we may prevent our children from assuming those same patterns.

. . . There are enormous numbers of adults in the world who lack security, who have lacked security from infancy, and because of that lack of security are available as followers specifically of those people who have excessive needs for power . . . It becomes clear that the first necessity is to produce a degree of security in small children that will make it unnecessary for them to search for security in peculiar and unworkable ways when they become adults.[11]

To this ringing appeal has come a recent echo from India through Manu Meta Desai, professor of social work at the Tata Institute in Bombay, who writes:

The major responsibilities of Indian parents today therefore lie not in helping their children to accept and follow traditional ways and standards but to help them evolve a new synthesis between the old and the new, with a minimum of strain and a maximum of ease, as well as to impart in them a sense of loyalty and responsibility to groups and peoples far beyond the limits of their narrow family caste and community life.[12]

First we must emphasize the importance of developing in the child a sense of human dignity and worth. This of course can only be a reflection of the human dignity the child sees in his father and mother. An infant gets his feeling of security from the affectionate and tender care of his parents—not from a realization that father is a person of authority and strength, who can militantly defend the home.

Next, we must avoid passing on to children all the prejudices, choices, and cherished biases by which adults subtly lead children to discriminate against others because they are poor, or have a different shade of skin, or worship in a different temple, or happen to be physically or mentally handicapped in some way. And that means that we must help our children early in life to meet with others beyond the family circle, in play groups or nurseries where there are not just those who are alike, but also others who are different.

Conflict in Generations

Of course there will aways be some conflict between generations. Age differences make this as natural as the friction in moving parts of a machine. But there is more than that to the conflict between the generations today. Young people are deeply confused by the inconsistencies and insincerity of their elders. We push them ahead in adolescence, yet hold them back as they reach the threshold of adulthood. We surround them as children with sexual stimulation in sound, print, and picture, yet try to impose on them rigid taboos against sexual behavior in their adolescence. We open vistas of a technological wonder-world of the future, and at the same time seem to be racing down the road toward world destruction. We are quick to complain when young people cannot get along in the new-fashioned world, but show our own limitations by recommending "old-fashioned discipline" for their problems.

Suggestions for Services

What are some of the ways of strengthening family life for bridging the gap between the past and the future successfully?

First, we must always be mindful that millions of children in this world still do not have enough to eat.[13] While we are considering the psychological needs of children, we must never for one minute forget the urgency of the world's hungry children. Their needs must be met through emergency aid and farsighted economic planning.

Second, parent education must become a wider concern. Groups of parents meeting to learn about child care have been spreading rapidly in Europe and America for the past few years. But at the same time considerable opposition to such groups has arisen from professional persons, some of whom are too impressed with their own psychotherapeutic skills to recognize the possibilities of an educational program; and some of whom are justifiably reacting to programs so inferior as to be of potential detriment.

However, under competent leadership parent education can be a most important tool in helping parents come to a better understanding of themselves and their children. Might it not be that in the past many parents responded poorly to child-welfare programs because no effort was made to help them understand their children's needs—the same needs which the services were trying to meet?

Third, we should think a great deal more about wide-scale parent participation in the initiation, policy formulation, promotion, and even administration of needed services. Too long, perhaps, have child-welfare workers looked upon the parents of the children in their care as clients rather than as

coworkers. In recent years the parents of handicapped children, particularly of mentally handicapped children, have brought forth in several countries legislation, financial support, and services for the handicapped which not long ago few thought feasible and no one even dared to predict.

Such movements present many difficulties for professional persons, but they hold vast potentialities for the well-being of children.

Fourth, the rapid progress of industrialization and urbanization requires a considerable increase in services to support, but not supplant, the family. In order to meet these needs we must constantly reevaluate our services—with courage to discontinue the outdated, with imagination to invent new ones, and with much greater readiness to work with other professions than our own.

Above all, we must make sure that we do not through our own organizations continue traditional patterns, such as authoritarianism or prejudice, not suitable for our era. Do we in our approach to adolescents implicitly perpetuate such patterns in family life?

Fifth, we badly need careful, large-scale research projects involving countries all over the globe to assess developments everywhere and to make sure that we learn from each other. But before we can undertake these, we need to improve our means of communication by working out common terminology and definitions in the sciencies of human behavior. In order to get support for expansion of services, we are also going to have to do some cost accounting to learn whether or not the services being rendered are truly good public investments.

Some time ago sociologists began to question the sociological validity of the practice of some of the persons who had provided the psychological working hypotheses on which modern social services are based. They pointed out that there often was a considerable cultural difference between social workers and the clients they were trying to serve, resulting in psychological misdirection and misinterpretations. As we who are concerned with services to families and children lean more heavily on the sociologists for our concepts, we might look at the psychological orientation of our sociological collaborators, so that we know to what extent their counsel may be colored by psychological motivations. And certainly we must subject ourselves to the same searching inquiry. If not, we shall certainly fail our children.

---

[1] U. S. Committee of the International Conference of Social Work: Proceedings of the Eighth Assembly of the International Conference of Social Work, Munich, 1956. *In* Industrialization and social work. Carl Heymanns, Cologne and Berlin, 1957.

[2] World Federation for Mental Health: Mental health aspects of urbanization; report of a panel discussion conducted at the United Nations by WFMH. London, 1957.

[3] United Nations: Report on the world social situation; prepared by the Bureau of Social Affairs, United Nations Secretariat in cooperation with ILO, FAO, UNESCO, and WHO. New York, 1957.

[4] Davis, Kingsley: The origin and growth of urbanization in the world. *American Journal of Sociology,* March 1955.

[5] UNESCO: Education and mental health; a report based upon the work of a European conference called by UNESCO in Paris, November–December 1952. Paris, 1955.

[6] Bettelheim, Bruno: Fathers shouldn't try to be mothers. *Parents Magazine,* October 1956.

[7] Zelditch, Morris, Jr.: Role differentiation in the nuclear family; a comparative study. *In* Family, socialization and interaction process. Parsons, Talcott; Bales, Robert F. Free Press, Glencoe, Ill., 1955.

[8] Josselyn, Irene M.: The family as a psychological unit. *Social Casework,* October 1953.

[9] Ross, Helen: Emotional needs of the young child; and Senn, Milton J. E.: Permissiveness in the early years. *In* Our children today; a guide to their needs from infancy through adolescence. Viking Press, New York, 1952.

[10] Mead, Margaret: Changing patterns of parent-child relations in an urban culture. *International Journal of Psychoanalysis,* November–December 1957.

[11] Chisholm, Brock: A new look at child health. *The Child,* May 1948.

[12] Desai, Manu Meta: The child in the Indian family. *Social Welfare,* April 1957.

[13] Mayo, Leonard W.; Arneus, Torsten; Houwer, Daniel Q. R. M.: The future role of the International Union for Child Welfare and its members. Based on a study under the direction of Katharine F. Lenroot. International Union for Child Welfare, Geneva, 1956.

Perhaps the greatest hazard for the public administrator in the welfare field is the theory that makes of administration an end in itself, a triumph of technique over purpose.

Norman V. Lourie to the 1958 forum of the National Conference on Social Welfare.

Increased knowledge about causes, more refined diagnosis, and more effective treatment may result from . . .

RESEARCH TRENDS IN MENTAL DEFICIENCY

MORTIMER GARRISON, JR., Ph. D.
Research Specialist in Mental Retardation, Division of Research, Children's Bureau.

ONLY A FEW years ago persons engaged in research showed little interest in the problems of mental deficiency. While there were exceptions, most research workers were unable to see any direct connection between their work and mental deficiency. They might express interest and recall having heard a lecture on the subject but this was about the limit of their familiarity with this field of research. Sarason and Gladwin,[1] in concluding their survey of psychological and cultural problems in mental subnormality, noted the disappointing quality of research being done in institutions for the retarded and the "disinterest of behavior science departments (psychology, anthropology, sociology, psychiatry) in the area of subnormal functioning."

To put it crudely, one might say that mental retardation simply was not popular. Funds, thinking, and personnel have been engaged in other directions. While the desirability of research was recognized by institutional staffs, their geographical isolation from universities and their budget limitations forcing them to focus on pressing service needs have combined to stunt the growth of research and training in the field.

In the past 5 years, effort on the part of the parents affiliated through the National Association for Retarded Children has resulted in considerable stimulation in all aspects of the field, clinical and research alike. It is to their credit that they have recognized the need for research even though they know this implies commitment to a long-term and, more often than not, unspectacular grind. It is well recognized that the complexity of the factors involved in mental retardation requires research in many disciplines if a more adequate understanding of treatment, cause, and prevention is to be developed.

An immediate result of this stimulation has been an increase in the number of projects under way involving the mentally retarded. These range in a broad sense from efforts to provide more trained personnel for work in the field as at George Peabody College [2] to the special diagnostic clinics supported by the Children's Bureau.[3] As part of this general stimulation the National Association for Retarded Children, the National Institute of Neurological Diseases and Blindness, the National Institute of Mental Health, the Association for the Aid of Crippled Children, and the New York Foundation have jointly supported surveys of biological, psychological, and social problems in mental retardation.[4] A project on technical planning in mental retardation being conducted by the American Association on Mental Deficiency, now in its third year, has involved a variety of activities designed to stimulate improvement in research, training, and program development.[5]

These general projects have underscored the necessity of closer association of the institutions with universities and medical schools in order to break down the isolation of the field and to bring in those whose interest in basic research problems will revitalize the concepts used in mental deficiency. Such

general ferment will do much to erase the stereotype current in too many minds that the retarded are poor subjects for research and treatment.

The improvement in the amount of work being done may already be noted in the number of abstracts of work in progress reported in the Children's Bureau publication, *Research Relating to Children.*[6] Although purely medical studies that are only indirectly related to mental retardation are usually excluded from this listing, recent issues of the bulletin have cited 87 studies of various types now being carried on.

Within the Department of Health, Education, and Welfare, the Office of Education has contracted for projects in six areas: (1) the definition and identification of the mentally retarded; (2) learning characteristics and responses; (3) language and communication difficulties; (4) teaching methods and procedures; (5) the effects of different types of school organization; and (6) postschool adjustment and other problems. The Office of Vocational Rehabilitation has initiated and proposes to expand a number of projects aimed at investigating ways of effectively rehabilitating the retarded through various means: the use of special workshop training, counseling, and the establishment of "half-way houses" as an aid to the retarded placed in their first employment.

The National Institutes of Health in addition to its training grants is supporting research on the basic etiological factors in mental retardation and allied disorders such as cerebral palsy. These studies range from discrete investigations of metabolic processes to a comprehensive collaborative study in cerebral palsy and other neurological and sensory disorders of infancy and childhood in which data uniformly collected in a number of medical centers throughout the country will be pooled for analysis.

The Children's Bureau through its operating divisions is supporting clinics aimed at early diagnosis and treatment and is attempting to expand and strengthen social services to the retarded through consultation in community planning and the provision of staff development and training opportunities. While the Bureau has no provision for the direct support of research a variety of studies may be expected to develop from this program.[3]

The Behavioral Sciences

In the behavioral sciences an interesting shift may be observed away from concentration on the use of psychological test-score patterns used to delineate subgroups toward studies designed to tease out the specific difficulties which may exist with respect to some achievement, or to determine how a particular treatment may affect individuals in order to know better how to proceed educationally and vocationally.

Woodward and her coworkers [7 8] at the Lenox Hill Hospital in New York City have reported on their 3-year study of preschool children, emphasizing the importance of psychogenic factors in inhibiting mental growth. Whether or not their efforts at treatment will prove to be successful is not known, but they do focus attention on the necessity for early identification and treatment in children without detectable organic defect. A somewhat similar project being carried on by Kugel and his associates at the University of Iowa is briefly reported in the Here and There section in this issue of *Children.* (See page 35.)

Griffith and Spitz [9] have studied the process of abstraction in high-grade retardates. When such youngsters are asked to give the property common to three nouns they tend to be successful when they have independently been able to define two of the three words in terms of a possible abstraction. That is, if they define chair and table when these are presented in a vocabulary list as "furniture," they may later be able to recognize that chair, table, and bed when presented together are all "furniture." The authors suggest an application of their work in the training of retardates through the teaching of a common description for several types of social behavior. For instance, meaning for the term "bad" might be developed from the association of "bad" with "punishable," or "cause for being returned to the institution" while these terms in turn are related to the specific items "fighting," "lying," and "stealing."

The importance of taking specific handicaps into account in program planning is illustrated by Hunt and Patterson's study of retarded children with visual or auditory perceptual difficulties.[10] When a brain-injured child with a difficulty in auditory perception is asked to sort out a series of pictures so that they illustrate a story to which he is supposed to listen he tends to concentrate on the pictures and blot out the auditory cues. This work has obvious implications for teaching methods and class composition. [See pages 13–16 for further discussion of mentally retarded children with perceptual defects. Ed.]

A method of measuring activity level has been described by Foshee [11] who used it to measure drive strength during simple and complex learning.

While the implications for program and treatment in this study are not immediate, the long-term results from the study of motivation and learning in the retarded should be considerable. McPherson has again reviewed the experimental literature on learning in the mentally retarded.[12] She reports 14 studies meeting her criteria for inclusion since 1948. While this represents a number larger than that reported in the original review, which extended back to 1904, it remains a very small number when it is compared with the mass of studies reported in the general psychological literature. From her review it is apparent that our knowledge of the learning process in the retarded remains fragmentary and confused.

Quantity and Quality

The studies briefly mentioned here can only indicate the diversity of work now being done in the field. Other investigators are evaluating the effects of socio-economic conditions and language barriers in school performance, the effects of the loss of the mother in infancy on growth patterns, and the self-picture of the retarded child in relation to his goals and level of aspiration. This diversity and quantitative improvement does not necessarily mean that better work is being done. However, there are signs of a qualitative improvement both in the kinds of questions being asked and in the experimental designs.

In general, instead of the comparison of groups on some psychological test score or pattern, more effort is being expended to investigate the psychopathology of mental deficiency. With a more specific knowledge of what is amiss in the learning, thinking, problem solving, personality, and socialization of the mentally retarded, it should be possible to make better predictions about success in education and rehabilitation than can be made at the present time from a knowledge of the I. Q. or of the fact that the individual is considered "brain-injured."

While this paper has focused primarily on the behavioral sciences, the same tendency observed there, the introduction of new concepts, and the relating of experimentation to current theory may be seen in other disciplines. Lippman's paper on the significance of heterozygosity for hereditary metabolic errors may be cited as an example of this.[13] This suggests how the application of modern genetic theory and techniques of investigation may shed light on the etiology of retardation in those people who at present are classified as "familial" or "undifferentiated."

With time, it seems inevitable that concepts and theories which have been found fruitful in the laboratories or in other populations than the retarded will be applied to research with the retarded. This in itself will do much to reduce the gap between university and institutional research workers and increase the useful knowledge about mental deficiency.

---

[1] Sarason, S. B.; Gladwin, T.: Psychological and cultural problems in mental subnormality: a review of research. *Genetic Psychology Monographs*, February 1958.

[2] Johnson, G. O.: Summary of Peabody research on exceptional children. *Exceptional Children*, September 1958.

[3] Hormuth, R. P.: Community clinics for the mentally retarded. *Children*, September–October, 1957.

[4] Masland, R. L.: The prevention of mental retardation; a survey of research. *Journal of Diseases of Children*, January 1958 (Part II).

[5] Nisonger, H. W.: Status of the AAMD project on technical planning in mental retardation. *American Journal of Mental Deficiency*, September 1958.

[6] U. S. Department of Health, Education, and Welfare, Children's Bureau: Research relating to children. Bulletins 4–7. 1956–58.

[7] Woodward, Katharine F.; Siegel, Miriam G.: Psychiatric study of mentally retarded children of pre-school age—preliminary report. *Pediatrics*, January 1957.

[8] Woodward, Katharine F.; Siegel, Miriam G.; Eustis, Marjorie J.: Psychiatric study of mentally retarded children of preschool age: report on first and second years of a three-year project. *American Journal of Orthopsychiatry*, April 1958.

[9] Griffith, B. C.; Spitz, H. H.: Some relationships between abstraction and word meaning in retarded adolescents. *American Journal of Mental Deficiency*, September 1958.

[10] Hunt, Betty; Patterson, Ruth M.: Performance of brain-injured and familial mentally deficient children on visual and auditory sequences. *American Journal of Mental Deficiency*, July 1958.

[11] Foshee, J. G.: Studies in activity level: I. Simple and complex task performance in defectives. *American Journal of Mental Deficiency*, March 1958.

[12] McPherson, Marion W.: Learning and mental deficiency. *American Journal of Mental Deficiency*, March 1958.

[13] Lippman, R. W.: The significance of heterozygosity for hereditary metabolic errors related to mental deficiency (oligomentia). *American Journal of Mental Deficiency*, September 1958.

ATYPICAL CHILDREN WITH COMMUNICATIVE DISORDERS

WILLIAM G. HARDY, Ph. D.
Director

MIRIAM D. PAULS, Ph. D.
Associate

Hearing and Speech Center, The Johns Hopkins Medical Institutions, Baltimore.

WITHIN quite recent years there has been developed a powerful armamentarium with which to deal at the diagnostic level with the atypical child who has communicative disorders. Granted that much remains to be learned of the etiology and prevention of such disorders—particularly the facts of intra-uterine environment—the various techniques of measurement and description are becoming more refined and make more sense with each advancing year. However, with more and more children being brought through catastrophic perinatal events and maintained in good health, the numbers of multiply-handicapped children have been steadily increasing.

It becomes readily apparent to the student of epidemiology and biostatistics that a large proportion of the children who are atypical—that is, who need special help in development, in learning, and in social and emotional adjustment—have one combination or another of communicative disorders. Something is sufficiently wrong with their hearing, language development, or speech, alone or in combination, so that these disorders in themselves constitute fundamental difficulties in development, in learning, and in social and emotional adjustment.

It has been society's bent to think of these children according to primary and secondary handicapping conditions, and therefore to begin therapy in terms of the so-called primary problem. In many respects, this is an unsettling idea that is only quasi-logical, and probably represents only one among many possible perspectives from which a child may be viewed.

From this perspective, however, one may see retarded children who are deaf, deaf children who have either the athetoid or spastic form of cerebral palsy, spastics with dysarthria (a neural breakdown in the motor speech system), athetoids with aphasia (an organic inability to use or understand words), aphasiac children with crippling skeletal conditions, rheumatoid children with reading disabilities, aphasiac epileptics, schizoid children with aphasia, and many other combinations. Apparently, this matter of labels may determine which of a number of dysfunctions is primary and which is secondary in the child's condition. Again, this is an unsettling idea, particularly when viewed in the light of a general commitment about concern for "the whole child."

A long step forward in clinical management is marked by the development in recent years of group diagnostic teams, wherein many paramedical disciplines are brought together for interaction around the central figure of the handicapped child.

The "integrated cleft-palate diagnostic group" is an example. A typical group includes representatives of pediatrics, plastic surgery, prosthodontics, orthodontics, dental surgery, otology, psychiatry, speech pathology, and social service, with none of these being either primary or secondary in the diagnostic task.[1] Procedural steps in a particular instance result from group appraisal and consensus, all aimed at a single goal, the best development of the child, which means achievement of the best possible communicative status.

Similarly, "diagnostic centers for multiply-handicapped children" are coming into being in a few medical centers. The driving force of this development has been the realization that in many instances of interclinic referral the child may be lost in the shuffle of a busy medical center, with a confusion of followup records and extreme difficulty in checking out the necessary steps in examination and treatment

of complex, multiple problems. The larger the hospital, the more apt this is to occur, particularly to children with chronic problems who must be handled at the outpatient medical-care clinic. This is the fault of nobody in particular; it stems simply from the fact that problems of interagency activity and referral, record keeping, distribution, and followup, scheduling or rescheduling, all involve a morass of paper work and rechecking which busy clinicians do not have time to do. It also stems from the shifting nature of a residency staff, the lack of coordination among specialty consultants, the pressures of various acute problems, and a variety of other aspects of the complex of modern medicine.

Complex Handicaps

Like other children, the atypical child with multiple handicaps, including one or more of the communicative disorders, badly needs to be viewed as a "whole child." What does such a view involve?

Child A exemplifies a common problem. She is 31 months old. Her mother had had 4 miscarriages prior to her conception, and during the pregnancy received hormones from the second month and was kept on frequent bed rest. Labor was prolonged; the cord was wrapped around the infant's neck at birth; the baby was cyanotic and was kept in oxygen for 2 days. There were no postnatal infections or diseases.

As the child grew the motor developmental landmarks were somewhat delayed, but not drastically. At 2 years of age, she showed no problem involving balance, but exhibited a slight lack of coordination in handling things. Her parents were uncertain about whether she had responded to sound in early infancy, but had not really become concerned about her hearing ability until she failed to learn to talk. At 31 months she had achieved only a rudimentary gestural language, which was unstable, no understanding of verbal language, and no speech.

Testing gave clear evidence of normal auditory peripheral function, but showed unstable perception of both pitch and loudness. This indicated a disorder of the central auditory pathways with, in all probability, a receptive language problem, aphasia. An extensive neuropsychologic examination confirmed this impression and also produced evidence of lack of central visual coordination in respect to memory for visual patterns. In spite of showing deficiencies in hearing, language, and speech, the examination gave clear evidence of reasonably good intelligence. This was supported by pediatric developmental neurologic examination in which the child showed no obvious symptoms of retardation except in these various sensory-perceptive areas. An electroencephalogram (recording of the brain waves) showed no frank evidence of an epileptic disorder, but gave some indications of hemispherical asymmetry of the brain and a definite slowing of two types of brain waves, the theta and delta waves.

In summary: The child was in good health after a stormy perinatal experience. No symptoms relating to her ears were present; her peripheral hearing mechanism apparently operated within normal range. There was clear evidence of a central auditory deficit. Central visual functions were not normal. There were problems in memory. Language development was aberrant. The electroencephalogram did not present a recognizable diagnostic picture, but was not normal.

What is this problem? Any of the classical labels is scarcely pertinent. The child can hear, but is deaf; she is retarded, but is not basically mentally defective; she can see, but cannot remember visual patterns, nor can she remember auditory patterns in time; she frequently responds to sound, but cannot discriminate what she "hears." Cortical function is obviously affected, but not in any classical form of "brain injury." She shows a slight lack of motor coordination, but not enough to imply cerebral palsy. She has shown no emotional symptoms beyond what would naturally accrue from communicative deprivation. Certainly this child suffers delayed speech, but this term does not describe her problem.

Actually, she has many problems, involving deficits in sensory functions, in perception, in memory, and in learning. She is a multiply-handicapped child, who needs reassessment regularly, a carefully designed program of parent guidance, and, later, a regimen of skillful teaching based on the diagnostic findings. There is no school placement which can be ideal for a child with such problems, except one which includes eclectic procedures and extensive creative teaching.

Unfortunately, this child is not a *rara avis*. In a busy clinic for children with communicative disorders, hundreds of children with these and other related problems are seen each year. They are atypical children, in terms of classical description, and in terms of one another.

A vast amount of attention is being paid these days to cerebral-palsied children. Most if not all of them have one aspect or another of hearing, language, or speech disorder. Some types of cerebral

palsy (or, rather, some of the causes of cerebral palsy) offer more predilection than others for specific communicative dysfunctions. Clinical experience shows, however, that it is usually better not to try to draw general conclusions from a type of cerebral palsy about a specific tendency in communication.

Individual Differences

Over the years, for instance, there has come into being the subconcept of "the deaf athetoid." Yet, while it is true that many athetoid children whose condition originated in Rh-factor incompatibility have impaired hearing resulting from a central lesion, it is equally true that some children of this type have entirely different kinds of hearing problems, or are aphasiac or dysarthric. Some have all three kinds of disorders, as do some children with other cerebral problems. All are children with brain injuries, but few lend themselves to traditional classification in terms of communicative problems.

On the surface a child with a cleft lip and palate would seem to present a clear-cut problem. Some do; many do not. All need the services of "the cleft-palate team," but the details of these needs can vary almost indefinitely with differences in developmental and social maturity, intelligence, familial environment, and the many psychosocial interactions that constitute the behaving individual. When the patient is a teen-age girl, who holds her hand over a scarred lip, who has no associations out of the home, and who refuses to go to school, the psychiatrist and the social worker become the most important members of the team. Until their work bears fruit, little else can happen. Then again, many children with cleft palates have fluctuating hearing losses. For many reasons, these children may be difficult to treat. In doing so the otologist and the pediatrician must give a carefully balanced consideration to anatomical, physiological, and psychological factors.

Among the atypical children with communicative disorders there is a large group referred to as "mentally retarded." Here, as usual, the details differ with each child. That he is retarded is usually fairly obvious; why, how, how much, and what he has to build on are questions with quite different answers for each. Many children are mentally retarded and deaf, or mentally retarded and aphasiac, or mentally retarded and blind.

One would expect the deaf, or aphasiac, or blind child to be retarded in several ways, for lack of either hearing, word comprehension, or sight leads inevitably to a large measure of communicative deprivation. It is most important that children who have been impeded in their development by communicative deprivation not be confused with children who are profoundly deficient in their capacities to learn. A vast difference lies between the potential of the child who is biologically deficient in capacity to learn, and that of the deaf or aphasiac child who functions suboptimally because of sensory, perceptive, or mnemonic deprivation.

Another group of children with combined handicaps which are often extremely abstruse, are the so-called "emotionally disturbed." A principal diagnostic objective is the attempt to discern whether the obviously disturbed child has emotional problems which are fundamental aspects of personality and self-appraisal, or are sequels to sensory, perceptive, or mnemonic deprivation. Many deaf children become so communicatively frustrated by the time they are 3 years old that their emotional disturbance may overshadow the basic problem.

At one extreme of possibilities among emotionally disturbed children is the child with the Straussian syndrome—completely distraught by problems of perception. He simply cannot organize his world through the sensory and perceptive functions at his disposal.

At the other extreme is the schizoid child, whose world is relatively well organized in sensory and perceptive terms, but for whom this does not make any difference. He is away from it, in any sense of the direct relationship of ordinary values. He may carefully step over every toy in the room, while maltreating the instep of every adult present. He may commonly *not* respond to sound, not because he is deaf, but because sound is not an acceptable stimulus for him; he does not want it.

Between these extremes are many combinations and degrees of emotional states and communicative handicaps, resulting in one or another aspect of the deviation from normal reactions called "disturbance." It is important for the clinician not to confuse *lack of response* with *inability to respond*, so far as the sensory systems are concerned.

Speech Disorders

Among the defined speech disorders (exclusive of stuttering, a speech dysrhythmia which is a symptom of an underlying anxiety state) perhaps 70 percent are usually grouped under the rubric "dyslalia" or "functional articulatory disorder" as distinguished from an impediment caused by cleft palate or some

other clearly discernible structural inadequacy. Clinical evidence has been growing rapidly (though not experimental evidence) to indicate that many children suffer a natural inability to monitor their own speech output with precision.

The obvious disparities of the lispers and the lallers from normal speech indicate an inadequate kinesthetic development. This too may be a result, however, not a cause, the basic difficulty residing at the sensory-motor level in an inability to remember the details of sound-sequence from the speech of another person. An extreme form of this is a disorder called "cluttering."

The clutterer may share with the stutterer the usual forms of perseverative or retardative dysrhythmia, but far from being burdened with an anxiety state the clutterer does not care what he says. He cannot monitor himself sharply, and simply bumbles along, expecting the world to do the best it can in making sense of his utterances. He is like the trained mule; he can perform well if one can get him to pay attention to the demands of the occasion. The mule may require the ministrations of a club; the child needs speech training by a sergeant major.

At another extreme, an aphasiac child in early infancy may have shown clear auditory orienting reflexes, but later, not being able naturally to learn and remember verbal symbols, may have inhibited the reception of sound, commonly enough all sound, environmental as well as verbal. The young epileptic not infrequently goes through a similar repressive stage. The problem of these children is not that they do not hear. The problem lies at a higher organizational level, an inadequacy in memory for the symbols of sound and a resultant failure in ordinary reflexive responses to sound of any kind. In some respects, it may well be that these children learn "not hearing" as a kind of defense or adaptation to a confusing world.

The Listening Mechanism

This commentary would be incomplete without reference to the organic listening mechanism. Current experimental evidence quite clearly demonstrates the existence of a neural network, including not only afferent fibers but a complex set of efferent fibers which compose a central alerting system for the hearing end organ, the ear. It seems obvious that many of the clinical entities which entail sensory and motor disparities, auditory and otherwise, may involve this alerting system at any point from the cortico-thalamic tracts to the peripheral structures. Children with involvement here need consistently to be alerted to sound and to be taught to attend to it, so that the various complexes of environmental sound may become sources for learning and for normal relationships with the social world.

We have, then, not a simple straightforward picture of hearing in terms of a black-and-white, you-do-or-you-don't kind of behavior. Rather, the various communicative disorders represent some form of breakdown in a sensory-motor continuum. Hearing, language, and speech are not unrelated operations. Naturally, they may be studied as though they were, but the studying does not make them so. On the contrary, in developmental terms, these various aspects of receptive and expressive behavior are inextricably bound together in a kind of feedback loop of relations between the individual and his environment. A child hears, learns to listen, learns language, learns to talk, learns to hear himself, listens to himself in comparison with what others say, and so on. Any serious interference with or breakdown of this self-monitoring loop may profoundly upset its integrity.

Because of the nature of common causes and effects, a large proportion of atypical children have real difficulties in hearing, in learning language, or in speaking. A historical label—the deaf child, the child with delayed speech, the retarded child, and so on—does little justice to the complex of the communicative disorder, or to the effect on "the whole child." The point is not that some deficit in a child is primary and another secondary, but that there is communicative confusion in the way the child can relate to his world. The various confusions in this regard require insightful recognition and handling, not as entities but as part of the total picture of the child with multiple problems.

---

[1] Baker, Herbert Koepp: Cleft palate habilitation—present tense. *Children*, May–June 1955.

Through eight years of experimentation North Carolina is finding ways of . . .

SURMOUNTING THE HURDLES TO HOMEMAKER SERVICES

MYRTLE P. WOLFF
Director, Division of Child Welfare, North Carolina State Board of Public Welfare.

AFTER SEVERAL years of experimentation, the North Carolina Board of Public Welfare believes it has found a way of encouraging the development of homemaker service to children in both urban and rural areas.

Of all the services which have been established to benefit children, homemaker service has been among the slowest to grow. It seems paradoxical that today when child-welfare workers are convinced of the importance of keeping children in their own homes and of strengthening family life, they have such a difficult time in building up a program which has these two goals.

The recent directory of homemaker services compiled by the U. S. Department of Health, Education, and Welfare [1] reveals that the 145 homemaker programs existing in the spring of 1958 were located primarily in the largest cities of the country and were operating primarily under private auspices. It also shows that since 1950 the number of agencies providing some type of homemaker service had more than doubled. This may seem tremendous growth, but there were still 16 States with no programs at all while few States had programs that reached out into rural areas.

In some States where programs have been developed a number of problems discourage expansion. These problems appear to be most acute in small agencies. No one seems to question the value of homemaker service as a tool to keep families together and to strengthen family life. But where does it fall in the list of priorities of service in our child-welfare programs? Usually pretty far down the line.

Why is this? Is a homemaker service a luxury only the wealthier counties and private agencies can afford? Why does it not stir the imagination of public-welfare administrators or community leaders? Is everyone aware of its potentialities? Does it lack professional status? Is it confused with maid service? Have child-welfare workers given sufficient time to its interpretation and if not, why not? Or is there an impediment in staffing? Are good homemakers hard to find? How can child-welfare workers help?

The experience in North Carolina points to some of the answers to these questions.

The History

In 1947, the State Board of Public Welfare using Federal child-welfare services funds initiated a demonstration of homemaker service in three counties, two rural and one urban. Since the State had (and still has) a locally administered, State-supervised public-welfare program, the county departments of public welfare employed and supervised the homemakers though the Federal funds paid for their salaries and travel. The three counties were selected because of their interest in offering the service and because they had other basic services such as a foster-home program already established. In each county two homemakers were taken on as regular employees of the local welfare department with merit-system status. They had suitable office space and were covered by the same personnel practices, except for

Based on a paper presented at the 1958 Southeast Regional Conference of the American Public Welfare Association.

489784—59——3

working hours, as were all the department's other employees.

The original plans for the program are described in a 1948 report of the division of child welfare. Briefly these were:

Qualifications of homemakers. In general the merit system qualifications decided upon included: successful completion of elementary school and 2 years of successful homemaking experience, either in own home or in a paid capacity; good physical condition; ability and personality to work with children and parents; good judgment, tact, resourcefulness in meeting situations and problems in the home; ability to make flexible adjustments; and good moral character; all this to be determined through interviews, physical examination, and references' statements.

Compensation and hours of work. Since the homemakers might be used for day care or for 24-hour service, it was necessary to establish work hours and a compensatory pay plan. The work week was set at 39 hours, the same as for other local staff members. Any time over 48 hours of work a week put in by a homemaker not serving on a 24-hour basis was compensated for by allowing an equivalent amount of time off. If the homemaker was employed on a 24-hour basis, she was to be paid one and one-half times the base salary and to be given a minimum of one-half day off per week.

Each county was to set a salary in line with the existing wage scale in the respective counties, to be approved by the State Board of Public Welfare. Provision was made for meeting expenses of transportation to and from assignments and for reimbursing the homemaker for other expenses by means of an expense and subsistence allowance. Like other workers, the homemaker was expected to pay expenses of transportation to the agency to report for work.

Two items of expense were made the responsibility of the county during the project. One was the provision of office space, supplies, and equipment needed to carry on homemaker services and the other was to meet needs of families requiring other assistance for the homemaker's service to be of any avail.

Types of situations. Homemaker services were to be provided to families on a temporary basis in the following situations: (1) when the mother was ill, had deserted, or had died; (2) when the mother's temporary absence from home for some other reason was resulting in neglect of the children; (3) when a foster mother was ill; (4) when there was otherwise a temporary need for special care in a family in order to prevent neglect of the children. Temporary care was defined as service for one month or less and in exceptional cases might be extended to 3 months.

Eligibility for service. Services would be available to clients of the agency, any person applying to the county welfare department for homemaker service automatically becoming a client upon determination of his eligibility for the service. In order to keep the project as simple as possible, it was decided that the local departments of public welfare could not allow other agencies to purchase the service.

Determination of eligibility was to be based on the inability of the applicant to meet 100 percent of the agency's public-assistance budget for aid to dependent children. This was the same as the method used to determine medical indigence. The services were to be available to families of any size. Selection of families to be provided homemaker services was the responsibility of the caseworker and his supervisor, with the approval of the local administrator.

Role of the homemaker. The function and role of the homemaker as an integral part of the social agency's service was a basic feature of the project. Manual material carefully set out a plan for the social-service aspects of homemaker service. The role of the caseworker in helping families using homemaker service was recognized as an important factor in determining its effectiveness. At all times the caseworker was to give continuing casework supervision to the families participating in the project.

The definite principle was established that homemaker service was to be used as an alternative for foster care. It was not then planned for use as a teaching program for families needing help in regard to budgeting, meal planning, marketing, and housekeeping. It was expected, however, that in many instances the homemakers would have an opportunity to stabilize a home and strengthen the family ties by training children within the home. It was stressed that all plans involved the cooperation of the responsible adult in the family group and his or her full acceptance of any changes that might be suggested.

In no instances was the homemaker used without the full cooperation of the parent or parents. The service was not superimposed but was used only when the parent or parents wanted to maintain their home and when the use of a homemaker meant a constructive plan for keeping the family together.

Considerable time was needed for planning the homemakers' assignments, particularly in regard to

transportation, meals, and especially work hours. In order to be in school many rural children leave home early in the morning. Since family life in a rural community cannot be geared to a 9 a. m. to 5:30 p. m. work day, it was necessary in making the homemakers' schedules to consider at what period of the day their presence is more important to the health and welfare of a child. In some isolated sections the homemaker had to use taxicabs, which were expensive. In most instances it was necessary for the agency to provide a meal allowance for the homemaker in budgeting for the family since in all cases the families were living on marginal incomes or public-assistance grants. The homemakers' ingenuity and ability to adjust to new situations, and the caseworker's support and skill in working with her were necessary to the effectiveness of the projects.

Evaluation of demonstration. Many of the problems which arose were due to the fact that demands upon the time of persons responsible for the projects limited the amount of interpretation and supervision they could give to the program in its first months. In some instances the need for these services reduced the homemaker's effectiveness. In the rural counties the problems of travel presented difficulties, but they were not insurmountable. In some instances cases selected for homemaker service involved difficult social problems which tended to complicate areas of responsibility. This would probably be true in any agency which has a backlog of families with problems which might lead to long-time care.

After Eight Years

The demonstration showed that homemaker service is of immeasurable value to children in sparing them the trauma of separation from their homes and their families. This is without question its greatest contribution in a program for children. But the project also revealed a way of saving dollars and cents, since the salary of a homemaker proved to be less costly for the average family receiving the service than either an aid-to-dependent-children allowance or foster-home care would have been. This was true because most of the families helped had four or more children. It would not have been true with small family groups. However, not many small families had applied for such help.

"Homemaker" became a permanent, classified position under the merit system. Federal child-welfare-services funds were used to reimburse counties for homemakers' salaries as for all other approved child-welfare positions—100 percent of salary for the first year, 85 percent for the second year, and 65 percent for the third year and thereafter.

At the conclusion of the demonstration in the three counties, only one, the urban county, retained the program. With relatively small administration budgets and staffs, the other two counties found their share of the cost of two homemakers too high in relation to other staffing needs. Two more urban counties initiated a homemaker service shortly thereafter. Thus three urban counties were providing the service in 1955 when the North Carolina State Board of Public Welfare reviewed the programs in detail.

Some of the original difficulties still existed, some new ones had developed, but many had been solved. The county agencies themselves made many suggestions for improving the service. The three counties with homemakers reported their intention of continuing the service because of its value but did not know what to do with homemakers "between jobs." In one county the homemakers were allowed to remain at home during such intervals although the administrator doubted whether this was fair to other staff members. In another county, the homemakers filed correspondence and repaired used clothing, and in the third county the homemakers made clothes.

Here obviously was a serious problem. Was the answer to pay homemakers on an hourly basis? We looked to Colorado, a rural State, which has had a homemaker program since 1937. Their homemakers were screened and approved much as were foster parents. As cases needing homemaker service arose, the county departments of public welfare applied for use of an approved homemaker and the State welfare department's division of child welfare passed on each application. While this plan had worked well in the early days of the program, during World War II the homemakers accepted full-time, regular employment elsewhere and continued to do so afterward. Though some few women preferred employment on a case-by-case assignment, most preferred steady work. Colorado, we found, was about to change to North Carolina's plan.[2]

This confirmed our opinion that we were on the right path so we looked at the homemaker program again. Could we broaden the responsibilities of the homemaker to include service not only to families in which the mother or foster mother was out of the home or incapacitated, but also to families in which the homemaker could teach inadequate parents how to give their children better care? This type of

service had been specifically excluded from the original list of the homemakers' responsibilities. After getting the Children's Bureau's approval to use Federal funds in this way the State Board of Public Welfare broadened the definition of homemaker service to include service related specifically to maintaining and raising the standards of a family's home life.

Two other policies were changed. One eliminated the "temporary care" qualification which had restricted service to one month or less or to three months in "exceptional cases." These restrictions had been found to be too limiting. Many mothers were out of the home for longer periods. Moreover, in the new "teaching" aspect of service, mothers often needed help week in and week out for many months. Therefore, the time limits were deleted from the regulations. The other change liberalized the definition of financial eligibility. This was broadened to include applicants who could not meet 100 percent of the budget used to determine eligibility for school health and crippled children's services, a budget substantially higher than the aid-to-dependent-children budget formerly used as a criterion. In this way more families with marginal incomes could be helped.

In a Rural County

Since then three more counties, two of them rural, have added homemakers to their child-welfare staff. In the rural counties because of the small population the numbers of cases with mothers or foster mothers out of the home or incapacitated are very few. In the great proportion of families using homemakers the mothers need help in budgeting, in buying, in learning to mend, to can, to prepare special diets, to bathe infants, and the like.

One of these counties is Bladen County, with an estimated population as of July 1958, of 31,800, the largest town having a population of some 1,700. Between February 1957 and January 1958 the county's two homemakers served a total of 65 families, 51 of whom were receiving aid-to-dependent-children allowances and 14 of whom were receiving no financial assistance. Of these, 11 had been closed and 54 were still active as of January 1, 1958. The length of time the cases were active varied according to need and use of the service.

Following is a summary of the Bladen County service.

The homemaker ordinarily spends from 1 to 4 hours in each home visit. The frequency of the visits vary. Some families require daily visits at the beginning. The visits, however, are usually on a weekly, semimonthly, or monthly schedule. There is no limit to the length of time the homemaker can stay in the home as long as her service can meet the needs of the family.

The homemakers keep day sheets recording their family visits and make notations as to major services rendered. They keep notebooks for their own convenience and for use in conferences. The caseworker makes an entry in her case record of the services given and how the family has used them.

The cases are selected in conference by the caseworker and the superintendent of public welfare, who is also the supervisor. The family is prepared for the service by the caseworker. The homemaker is introduced to the family by the caseworker.

The homemakers have selected parents to be invited to demonstration conferences held by a nutritionist from the State Board of Health, at which the nutritionist talked about food values and demonstrated the preparation of balanced diets from low-cost foods. These conferences were held once a month for a 6-month period from 9 a. m. to 11 a. m. while the children were in school.

Let us look at a typical family, a deserted mother and five children receiving an aid-to-dependent-children grant. At the time the homemaker service was initiated this family had very little clothing or furniture. The children's school-attendance record was poor.

The homemaker has made weekly visits in this home. Through budgeting, planning, and some carpenter work carried out under the homemaker's supervision the family has improved living conditions. Several pieces of used furniture have been purchased. The family standards have improved and the children are now regularly in school.

One child had rickets. The homemaker helped the mother plan the recommended diet for this child who has since fully recovered.

In another family receiving homemaker service both the parents are slow mentally and the mother is also a polio victim. There are three very young children.

The homemaker and child-welfare worker have worked very closely with this family. With help in home management, in how to bathe the babies, in how to budget and buy, the mother has been able to cope with her responsibilities more adequately. The family frictions have lessened and the relationship between the parents has been strengthened.

This was a new approach to the use of homemakers in North Carolina. It is being used to an even greater extent in the new demonstration program the State has recently set up for using homemaker service to help older people.

Now with a greater potential in caseload, it is possible to keep the homemaker busy. There is no longer any period of waiting for a case to turn up. A schedule can be planned and work organized for a week or a month. If an emergency arises which demands priority, as when a mother is hospitalized and no other homemaker is available, the agency notifies a family having a teaching visit scheduled by a homemaker that the visit must be canceled and why. While this plan still presents some problems, the teaching visits may be planned with a kind of flexibility that is helpful in the administration of the service.

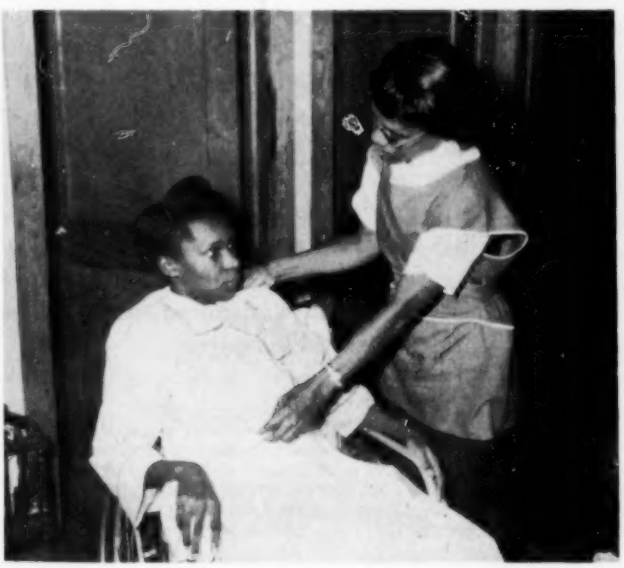
About Priorities

This brings us to a crucial point. There must always be enough time for adequate supervision of the program—not only in the beginning as the early report suggested. In large agencies the homemaker staff is generally big enough to be in a unit with at least one full-time supervisor. In small agencies the supervision of the service must be under a person who has other responsibilities. Because of pressures which may seem more immediate—public-assistance reviews, foster-care planning, juvenile-court studies, and other urgent tasks—little time may be saved for the homemaker. This neglect may be traced not only to the supervisor's methods of determining priorities, but also to the priorities which the administrator sets. It raises the question: Have public-welfare administrators given homemaker service the time and thought it needs to be as effective as other more familiar programs?

One fundamental problem in the development of homemaker service is that program planners do not attach the same importance to it as they do to other services. Is this because in the past by using it only in emergency situations, we grew to think of it as an emergency service—a temporary expedient—rather than as another resource for children as basic as, or even more basic than, foster-home care? Or is it that social workers look upon this service as somewhat less than professional because of the responsibilities and qualifications designated as the homemaker's?

It took child-welfare agencies years to accept foster parents as valuable members of the agency team. Child-caring institutions only recently began to recognize the key role that cottage parents play. Hopefully, it will not take long for homemakers to be accepted as members of the team. Hopefully, too, the caseworker can be helped to see that her skills as a social worker do not necessarily include skills in homemaking, that such skills can be provided by a competent homemaker. The caseworker's skill in-

In Wake County, N. C., a homemaker from the county welfare department serves a permanently disabled mother and her three children. Because this homemaker service for children has no time limitation it can be used to help mothers with chronic disabilities to keep their homes together, as well as to help families needing the service only temporarily.



cludes the ability to recognize her client's need for homemaker help and to prepare the client to accept it positively.

Thus it is obvious that a homemaker must have status—status with the agency's clients and with its other workers. She must be regarded as a member of the staff with special skills to contribute to the total agency program. She must serve on appropriate agency committees and must have the opportunity to attend appropriate conferences. And she must have as much opportunity for staff-development programs as have other staff members.

In North Carolina the homemaker now receives compensatory time for overtime, hour for hour, in accordance with agency policies on overtime. The original policy of payment of time and a half under certain circumstances has been discarded so that the same personnel policies and practices apply to her as to other employees.

There is a strong belief in North Carolina that homemakers must be very skillful people, prepared to adapt easily to new situations and new people, resourceful and patient, with ability to help individuals learn some of the principles of good homemaking; and that persons with these skills are entitled to salaries that compensate them adequately. The prevailing wage of a maid will get a maid. A homemaker has greater skills and responsibilities than a maid and must be paid more. The North Carolina salary maximum for a homemaker is $250 per month. None of the homemakers earn that much now, but the State Board of Public Welfare recommends a minimum of $200 and some homemakers are getting more than that plus travel expenses. Homemakers employed in rural areas have their own cars, thus solving the problem of transportation.

As for academic qualifications North Carolina has been most fortunate in securing persons with college backgrounds for some of its homemakers. All are married and have at least some high-school work. Selection, too, can be made with a view toward assuring status.

Training and staff-development programs are directly related to the fact that homemakers are employed by and supervised by staff in the county departments of public welfare. The orientation and inservice training programs have been the responsibility of the counties. However, as a result of a request from supervisors, periodic statewide workshops for homemakers are being planned by the State. We hope to learn from experience how to gear further staff-development planning; but we know now that the homemakers, their supervisors, and administrators want the program and want help in making it more effective.

Budget and Expense

One final point needs emphasis. Adding two homemakers to a small county agency budget looks rather expensive to the county officials who approve budgets and handle the purse strings. While child-welfare-services money carries the greater proportion of the salary, other expenses are involved. Moreover, all too often agencies have not been able to get approval for all the casework staff they need. They ask: "Are we justified in pushing for a homemaker program before we have adequate casework staff? If so, how do we sell it to our boards and county commissioners?"

These are the same questions which I asked almost 20 years ago as I tried to develop a foster-home program. I have learned two fundamentals which hold true regardless of the new program to be developed. First, no agency ever had enough casework staff. Therefore, if an agency waits for that happy day before moving to the new, that agency will never move. Certainly casework staff must have high priority, but too often lack of adequate staff is an excuse for lack of progress. The skillful administrator knows when and how to move. Secondly, an administrator who really believes that a public-welfare agency has a responsibility to help every person in social or economic need can find the courage and the ways to develop new tools with which to help people.

A great deal of information is available describing homemaker services generally. Currently, committees in various parts of the country are developing material to stimulate the establishment of homemaker services in both large and small communities. They are doing this as groundwork for the National Conference on Homemaker Services, to be held in Chicago in February 1959. (See page 36.)

The searching look being given homemaker services during this next year will give us new information and a new emphasis. Both will help as public-welfare programs are advanced to strengthen services to children and their families.

---

[1] U. S. Department of Health, Education, and Welfare: Homemaker and related services, 1958; a directory of agencies in the United States. Children's Bureau Publication No. 370. 1958.

[2] Perkins, Juanita V.: The homemaker-service program of the child welfare division of the Colorado State Department of Public Welfare. In the Proceedings of the 1957 National Homemakers Conference (mimeographed). National Committee on Homemaker Services, 1958.

A JOINT-INTERVIEW TECHNIQUE WITH MOTHER AND CHILD

ELEANOR S. WERTHEIM
Clinical Psychologist, Department of Psychiatry, Royal Children's Hospital, Melbourne, Australia

A TECHNIQUE of holding joint interviews with mother and child has been developed in the Department of Psychiatry, Royal Children's Hospital in Melbourne, Australia.

This development was stimulated by the limitations of the currently available procedures in clinical work with emotionally disturbed children. In outpatient practice these procedures rely mainly on samples of behavior obtained under specific conditions far removed from reality and involving one-to-one relationships between the clinician and the child, supplemented only by verbal reports.

The modification of the conventional practice of seeing the mother and child separately has been aimed, therefore, at improving the validity of the inferential jump from clinical data to real life by observing them together in a natural setting as far as this could be approximated in an outpatient clinic. This experience is reported in the hope that it may stimulate further research and thinking along these lines.

The joint interview with the mother and the child usually takes place in a playroom. The mother, child, and clinician become involved in a reciprocal relationship. During the process, a variety of materials useful for stimulating projective activity is introduced—puppets, clay, paints, or other toys. Generally, both the mother and the child are encouraged to use these materials in their own way. However, in some cases the verbal interview remains the basic tool of communication. Children in the latency period (ages 6–10) and younger have reacted most favorably to such joint activities although the technique has also been effective with some older children.

The technique makes it possible to assess: (1) the mother-child relationship; (2) the mother's functioning; and (3) the child's functioning. Its use necessitates the evaluation of: (1) the role of the clinician; (2) the value and limitations of the technique; and (3) its applicability.

Mother-Child Relationship

The opportunity to observe directly the interaction between the mother and the child enables the clinician to assess more accurately the nature of the mother-child relationship in both its affective and cognitive aspects and in regard to the distribution and degree of control.

The affective aspects can be gauged by noting:

1. Speech behavior—its content, inhibitions, tone of voice.

2. Nonverbal behavior—gestures and other subtle indices of their attitudes toward each other such as their spontaneous seating arrangement.

3. Areas of conflict and of harmony. For example, a mother may tolerate her child's masturbation but become angry when she sees him spill some paint on his jacket.

4. The degree of consistency in emotional reactions. This is particularly important to note as it can give clues to the interaction between the pathology of the mother and that of the child and to the child's response to shifts in maternal affect. For example, a mother who is subject to depression may accept

The author acknowledges indebtedness to Winston S. Rickards, M. D., Director of the Department of Psychiatry, Royal Children's Hospital, Melbourne, for the opportunity to develop and use the technique described here and to Martin B. Fliegel, M. D., Hawthorn Center, Northville, Mich., for discussions which helped clarify many of the issues involved.

her son's playful expression of aggression when she is feeling well, but react with intense hostility to identical behavior occurring while she is in one of her depressed moods. The same boy may display much more warmth when his mother feels well, but become withdrawn or aggressive in response to her depression and hostility.

In such affective interplay, both its conscious and unconscious elements become immediately apparent. For instance, a mother may turn to a child and say: "Go on, say something. Doesn't mother always tell you she loves you?" In remarks such as this, which are not uncommon, the denial of hostility, ambivalence, and the depth of feeling or its various substitutes can be witnessed directly in the form in which they operate on the child.

In a joint interview, it is also possible to detect quickly the presence of an unconscious affective link described by Adelaide Johnson through which the mother derives vicarious gratification from the child's unacceptable behavior.[1] The mother may laugh while she is scolding the child for wanting to take a toy from the playroom or she may try to explain away the child's behavior. The seductive elements in an otherwise hostile mother-child relationship are unmistakably revealed when a mother shrieks with excitement: "Don't peek! Don't peek!" as her son tries to see what she is painting, thereby encouraging him to do so and working him up into a similar state of excitement.

The *cognitive aspects* of the mother-child relationship may be inferred from both the overt and covert communication between the mother and child. A breakdown in *overt communication* between the two is one of the most common "symptoms" of an awry relationship seen in the clinical population. These two people live together and are involved in one of the most intimate relationships provided by society, yet tragically they often face each other like perfect strangers.

The joint interview dramatically exposes the limited and frequently distorted perceptions mother and child have of each other. In fact, in some instances, the protective presence of the clinician presents them with the first opportunity they have had to face each other squarely and to realize what they feel and how they influence each other's behavior. In less severe cases an experience of perceptual correction, thus achieved, removes the previous block in communication and may be all that is necessary to free mother and child for a healthier interaction through which they can work out their own solutions to the problems for which the mother sought help.

In all cases except those in which the child's pathology precludes verbal communication, such an experience provides an important first step in clearing the ground for a new relationship. Hearing her 7-year-old son tell about how worried he is about her staying up late and smoking continuously and of his desire to help her may come as a revelation to a hostile, relentless mother. Hearing his mother brag about his mechanical abilities may be no less of a revelation to a child who has experienced nothing but nagging and criticism at home.

In the process of carrying on various activities together, both mother and child expose numerous facets of their relationship, not only to the clinician but to themselves as well. For example, when a child invites his mother to join him in his play she may suddenly realize that she has never given him enough time at home. Or, watching the clinician's calm acceptance of the child's spontaneity or his messiness, a mother may for a moment become an impartial observer and perceive these activities in a new perspective.

The Australian experiment described here is one of a number of efforts today to bring reality into the process of treating emotional problems. In the United States departures from exclusive reliance on scheduled one-to-one interviews are most frequent in the forms of group therapy or counseling in which the interactions within a group of selected patients, or clients, are made tools of the treatment process. Some experimentation in simultaneously interviewing several members of the same family is also taking place in a few agencies practicing family-centered casework wherein the family as a whole is regarded as in need of treatment.

In another direction, but with a similar recognition of the strength of life as it is being lived in determining the outcome of treatment, are the on-the-spot treatment techniques being developed in small residential-treatment centers for extremely aggressive children, as at the experimental home at the National Institute of Mental Health, Bethesda, Md. There children are seen by a psychiatrist not only in scheduled interview sessions but immediately on the scene of action when and where an emotional explosion occurs.

Not uncommonly in a joint session, a mother may become aware of assets and positive qualities in her child which she did not see before. For example, a girl who has previously functioned poorly in every way may in this supportive atmosphere produce "works of art" in clay or painting and thus deal the first blow to her mother's conception of her as a "good-for-nothing." Similarly, seeing a child she has regarded as having "no heart and no sense of shame" blush unhappily while the clinician is told of the child's misbehavior forces the mother to reevaluate her previous conceptions. Needless to say, the experience of sharing and enjoying an activity with his mother also alters a child's perception of her by showing him her interest and willingness to give of herself.

Covert communication, the subtle type of communication which often creates marital difficulties, when spouses unconsciously respond to each other's pathological needs, also plays an important role in mother-child pathology. The way in which mother and child are aware of each other's unconscious needs is at times almost uncanny, although a thorough investigation would probably reveal observable perceptual processes at work.

The joint interview makes it possible to detect such psychological "dovetailing" and to assess its extent, degree, and temporal relationships. Much can be expressed through the projective medium of clay or paint or any other plastic material. From the ways in which mother and child use such materials simultaneously, insight can be gained into their fantasies and interaction. The playroom may be set up in a way to prevent the mother and child from seeing each other's productions while painting. Yet a later comparison of their work often reveals a subtle interplay between the two, the child's and the mother's fantasies mirroring or complementing one another.

The nature of the *control system* in the mother-child relationship can be observed as the mother and child handle the many different situations arising in the course of their joint session. The distribution of power, the methods used by each to gain or reinforce control, and the quality and degree of self-control in their dealing with one another become immediately apparent.

In the joint interview the clinician can easily distinguish insecurity or impulsivity from positive firmness in a mother no matter how hard she tries to "put up an appearance." No mother playing a studied role of a "good mother" could fail to reveal herself when faced with the kind of behavior on the part of her child which brought her to the clinic in the first place and which is very likely to show up at one time or another during the session.

"There will be no movies tonight so you better forget about it." With remarks like this to her child the mother gives better information about her method of handling him than reports on her disciplinary measures. They also help the clinician to assess directly the appropriateness of the controls to the child's age and abilities. Similarly, a mother's expectations for her child are demonstrated as she puts a coat on a physically normal 10-year-old girl or commands an active, spontaneous 5-year-old boy to "behave like a man." The clinician's handling of the child provides the mother with a model of alternative, more effective techniques of control. This can be much more meaningful and convincing to a mother than theoretical discussions with a worker who always sees her alone and has had no experience with the child.

While the affective, cognitive, and control aspects of a mother-child relationship have been discussed here separately, in practice they constantly interact as do diagnosis and therapy.

The Mother

The mother's initial perception of the clinician and his role depends, of course, on the basis of her referral. If the school or other external pressures are responsible for her visit, she can be expected to regard him as a threatening authority figure. If she is seeking help on her own initiative she is likely to invest him with more positive, benign authority.

In either case her feelings are mixed, but the original orientation always shows up in the first session, exposing in some ways how she relates to authority figures, and thereby throwing important light on some aspects of her own personality. These may show up directly in her interaction with the clinician, but in the joint interview she also reveals them indirectly through the child.

For example, a mother may invoke the clinician's authority every time she tries to reinforce her own order to her child. She may say: "Sit still—he wants you to listen," thereby betraying her own dependency and helplessness. Or she may reveal even more severe infantilism by unconditionally turning over her authority to the clinician. At the other extreme, a mother may see herself in a power struggle with the clinician and may attack him

verbally or take over direction of the session by manipulating the child.

Whatever the mother's motives in bringing the child to the clinic, her act of doing so represents an admission of her own inadequacy in managing him. This means that one aspect of the clinician's role in the mother's eyes is that of a judge who has the power to pronounce the verdict of "guilty" or "not guilty." To have her handling of her child openly exposed to another's scrutiny is distressing to any mother. Her response to this stress, the ease with which she can recover from it and adapt to the clinical situation, and the changes in her behavior as she feels more comfortable are valuable diagnostic indices of her own functioning.

The way a mother handles a projective activity, such as painting or play, also provides extremely useful clues as to various aspects of her personality structure and pathology. In our experience none of the mothers have ever refused to participate in such activity. It seems that in our overcivilized culture which offers adults few outlets for fantasy expression, the freedom for self-expression is basically gratifying. However, the provision of this opportunity in a clinical setting usually mobilizes some ego defenses. Therefore, the analysis of these defenses or their apparent absence can throw some further light on the mother's ego strength. With this in mind, it is profitable for the clinician to attempt to differentiate three aspects of the mother's projective activity: (1) its focus; (2) its content; (3) its form and level of organization.

The ease and rapidity with which a mother accepts an activity is usually significantly related to the *focus* she gives it. Some mothers regard the projective activity as part of a total program designed to help the child. They ally themselves with the clinician and even though they may enjoy the activity, they take part in it mainly for the sake of the child. In other words, although they momentarily regress to the child's level, they do so intentionally, as adults. On the other hand, a narcissistic mother uses the activity for her own ends and for her personal gratification. She seizes the opportunity to be a child once more and to interact with her own child on this level.

An important clue to the focus the mother has given to the activity is provided by the psychological distance of the *content*. This could range from emotionally peripheral to central issues as the mother's productions vary from impersonal to conventional or symbolic themes. In some cases they may openly express her problems, feelings, and mood. Such expressions reveal information about the mother's own needs and areas of personal conflict and have to be handled with extreme caution.

Form and organization of the content of the mother's activity, when analyzed along conventional lines, provide additional information about the nature of her control system and about her emotional and intellectual development.

Where feasible, the mother and the child are encouraged to talk freely about their associations with the nonverbal projections. What they say is then subjected to similar analysis by the clinician.

The Child

The child, in sharing the clinical session with his mother, reveals his physical and intellectual resources, skills, and deficiencies much as he does in an individual session through verbal interaction or projective activity or both. Either type of session provides the clinician with an opportunity to evaluate to some extent a child's capacity to relate to others and to accept limits. However, basic differences exist in what the joint interview reveals about other aspects of the child's emotional functioning.

At the very early stage of a contact, the mother's presence may give the child a sense of purpose and security but also limits his freedom. His hostility to her may inhibit his spontaneity while his dependence on her may make it difficult for him to behave in a way he knows would intensify her rejection of him. These inhibiting factors have both advantages and limitations from the clinician's point of view.

The way in which the child handles his hostility to his mother in the session indicates the quality and intensity of his ego strength and controls. From the demands he is making on her we can directly assess the nature and intensity of his emotional needs and the way in which he tries to gratify them. By comparing his reactions to the mother and to the clinician, the clinician can gauge the child's repertoire of feelings and their depth as well as his defenses.

However, in some cases, particularly of neurotic children, the more primitive layers of a child's personality may not show up at all. If they do, they usually appear as fantasy, for in a joint interview a neurotic child rarely relinquishes behavioral controls to the extent that he sometimes does in an individual session.

Thus, while the joint interview may be an invitation to regression for the mother, it may have the

opposite effect on the child. The clinician has to be aware of this in order not to overestimate the level of the child's emotional development.

Clinician

In classical child-guidance practice the clinician commonly sees the child and the mother one at a time. In group therapy he becomes involved in multiple simultaneous relationships, but the membership of the group consists of people who are not intimately related to each other and are more or less alike in age, mental development, patient status, and other important variables. In marriage counseling, and even in joint interviews with both parents, the participants do have close personal ties but they too are of more or less equal status.[2] But in joint sessions with mother and child, the clinician is dealing with two people who are not only intimately related to each other but are at widely different stages of development. Their role relationship is that of an authority and a subordinate who is physically, emotionally, and socially dependent on this authority. Their clinical status differs in that the child is the patient while the mother is not.

These important differences contribute to the complexity of the joint interview, which imposes much greater demands on the clinician and his skills than other types of therapy. Above all, it calls for considerable flexibility and the capacity to function simultaneously at different levels without personal discomfort and to assume many different roles in the course of a single session. It also requires the clinician to have come to grips with his own problems in relation to parental figures, as the joint mother-child interview more than any other clinical procedure offers opportunity for countertransference and one-sided identification with parent or child.

While the clinician avoids such identification at times he allies himself temporarily with the healthier aspects of the mother or the child whenever these come to the fore and attempts to strengthen them. On the other hand, the clinician accepts the acting out of hostilities within therapeutically beneficial limits.

The balance between withdrawal and participation on the part of the clinician has to be carefully gauged in order to prevent a mother from regressing further than would be safe for her parental status, or to avoid creating anxieties in the mother by seeming to take over her function. The clinician is dealing here with an important reality relationship which must not be undermined.

While a mother may develop an attachment, or transference relationship, to the clinician, so far a mother's hostility, or negative transference, has not presented serious problems. The possibility of this occurring, however, deserves a fuller scrutiny, for it could in practice create a most difficult and undesirable situation.

At this stage only two tentative explanations can be offered for the failure of this difficulty to appear:

1. To the relatively more mature mother, who focuses on the child rather than on herself, the clinician may represent the "good object," a helpful ally toward whom positive feelings are directed. Such mothers not uncommonly direct their negative feelings toward some "bad object"—an authority outside of the interview situation, such as a previous doctor who "did not know" or "did not help."

2. In the case of a more narcissistic, immature mother, who regresses for her own sake, the projective activity may absorb some of the negative transference as it often does in individual therapy with a child in the 6- to 10-year age group.[3] However, if this becomes prominent the joint interview has to be discontinued.

The child's transference relationships depend, of course, on his age, the stage of his ego development, and the presence and strength of repression. However, in a joint session he has an opportunity of working through his problems "at the source" in direct interaction with his mother.

Actually, the child's positive feelings for the clinician create the greatest technical difficulties. While these feelings must be preserved, at least during the first stage of the contact, they invariably arouse the mother's jealousy and so create a hazard to the therapy's success. The child never fails to make a dramatic display of his preference for the clinician. Few mothers would not be hurt by seeing their child offering candy or a special gift to the clinician but not to themselves. To overcome this hurdle, the mothers are now warned of this impending development, its meaning and importance are explained, and they are reassured of its transience.

In the course of the contact the strong positive attachment to the clinician is gradually partly transferred to the mother and partly dissipated as the child matures and becomes less dependent. Negative behavior on the part of the child is usually directly or indirectly aimed at the mother. When the behavior is dealt with by the clinician as it occurs, the underlying feelings can be related to its

rightful object and then resolved. Symptoms of hostility gradually decrease in frequency and intensity and become much more appropriate.

How one carries out the clinician's role in a joint interview depends on whether the primary concern is with diagnosis or treatment. The specific aim determines whether the clinician fully interacts with the mother or child or reduces his participation to a minimum by withdrawing into the background while they are painting, making comments, and perhaps arguing with each other. The clinician may intervene to clarify, reflect, and at times to interpret to the mother and child their feelings for one another as expressed through their words or actions.

Spoken emphasis is given to any evidence of positive movement on either side. At times it may be advisable to become directive in a nonauthoritarian manner by encouraging the mother or the child or both to express their feelings, to make use of the projective activity, or to seek a solution to a particular problem which has become apparent to both of them in the course of the session. Constructive suggestions may even be offered but always in a way which leaves no doubt as to their freedom to refuse them. In appropriate instances the child's regressive needs are recognized by assuring both him and his mother that it is all right for him to have as many cookies as he likes or to get dirty during the session. On the other hand, the mother may be given support by explaining to the child the realistic nature of her limit-setting.

On rare occasions it becomes necessary to assume an authoritarian role for the sake of psychological safety—as when the child or the mother is about to reveal inner feelings from which the other should be protected. In such instances, an alternative subject or activity may be introduced or steps taken for dealing with these feelings outside of the joint session. The use of humor is often effective when the mother and child reach a deadlock or when the tension between them reaches a dangerously high level.

The clinician must constantly be aware of being pushed into playing a role in which the mother and child want to cast him. Often they try to turn him into a judge by reporting to him each other's misdeeds, and expecting him to censure the guilty party. This can be bypassed by turning such reports into a discussion in which both are encouraged to describe the deplored event, their motives, and feelings about it. Thus they may be helped to gain a better understanding of each other.

Since this description was written the author's attention has been drawn to a paper by John Bowlby which reports the use of a joint-interview technique at the Tavistock Clinic in London.[5]

Value and Limitations

In a sense, the joint-interview approach is not new. It has been used with the preschool child [4] but it still has to be developed into a systematic clinical procedure with older-age children.

This technique provides a way of setting up a miniature "natural experiment" in which by deliberately manipulating the three main variables—the role of the clinician, the verbal versus nonverbal content of the session, and the nature of the projective activity—the clinician can multiply the conditions under which the mother, the child, and their interaction can be observed. It gives the clinician more freedom than is possible in an individual interview to vary his distance from the phenomena studied and to control the degree of his psychological participation. Although his very presence makes it impossible for him to escape influencing the situation, the validity of his observations is improved.

Diagnostically the joint interview has the advantage of being comprehensive. It provides simultaneous information about mother and child with little additional time investment. It allows for relatively quick and reliable identification of reactive elements or the degree of personal pathology in the child's disturbance. By making possible an assessment of the individual areas of strength in the mother and child, their limitations, their readiness, and their capacity for change, it provides a basis for prognosis and treatment planning.

As a treatment method the joint interview facilitates what Madeleine Rambert calls "the conscious realization" of conflicts, bringing the child "face to face with the problem he has previously been unable to resolve in order to give him a more satisfying solution to it." [3] It also helps the mother to achieve this in relation to the child. In the safety of the therapeutic hour, sometimes through make-believe, the mother and the child can reveal conflicts to each other which would otherwise be unacceptable.

For both mother and child the experience of joint sessions can be an extremely gratifying process of reeducation achieved through learning together to understand, to appreciate, and to live with one another. They do this as they interact with the clinician and with each other in the clinician's presence, secure in receiving his help in surmounting whatever hur-

dles block their communication. The fact that the mother participates in the child's treatment and becomes an integral part of it makes it much more meaningful to her. The shared experience brings mother and child together, increases their responsibility toward each other, and becomes a unifying influence outside of the therapy hour. Routine reviews of some of the cases treated in this way have indicated that even after 2 years the gains made during therapy were maintained in regard both to the mother-child relationship and to the child's personal development.

The potentialities of this technique for research are manifold. The procedure has many dimensions lending themselves to scaling. An objective scoring system would make it possible to investigate: (1) the basic differences in mother-child relationships in various clinical groups; (2) the relationship between the mothers' and the children's pathology; (3) the basic differences between the mother-child relationship in normal children at different age levels for the different sexes, and among different social and ethnic groups.

The procedure could also be adopted to study father-child or sibling interactions.

There seem to be no contraindications for the inclusion of this technique in diagnosis.

In treatment its main goal is to help the mother and child gain insight into their own impulses and needs through an improved understanding of their interaction and to learn to develop the controls and skills necessary for healthy personal and interpersonal functioning. Accordingly, the effectiveness of the treatment depends on careful case selection. For this, the following preliminary criteria are useful:

1. The mother should be reasonably intelligent.
2. The mother must possess enough ego-integration to be able to allow the focus of treatment to be on the child and not on herself. Any mother with serious pathology requiring psychiatric help in her own right must be excluded, for the child could be further traumatized by evidence of her disturbance.
3. No matter how intense the conflict some positive ties between the mother and the child must be present at the outset.
4. Severely disturbed children, whose egos have to be pieced together before reality relationships can be handled, must be excluded.

Place in Clinical Practice

The joint-interview technique is not suggested as a substitute for but as a useful adjunct to conventional diagnostic procedures.

In therapy this technique can be used alone or in combination with other approaches, depending on the nature of the problem. In some cases it can be used as the first stage of treatment during which intense surface hostility and tension between the mother and the child are worked through, affording immediate relief in their interpersonal relationship. It can then be followed by individual sessions with the same therapist. In other cases, where the joint interview remains the approach of choice, it may be necessary to see the mother additionally in an individual interview from time to time, especially if she needs to discuss problems peripheral to the focus of the joint session or if current developments in the session indicate the need for private discussion.

It is not always possible to decide *a priori* on the best course of action. This has to be evolved as the therapy progresses. If the therapist is sufficiently alert, sensitive, and flexible such adjustments should not present serious difficulties.

---

[1] Johnson, Adelaide M.: Collaborative psychotherapy: Team setting. *In* Psychoanalysis and social work, Part II. Heiman, Marcel (editor). International Universities Press, New York, 1953. (pp. 85–86)

[2] Hallowitz, David; Clement, Robert G.; Cutter, Albert V.: The treatment process with both parents together. *American Journal of Orthopsychiatry*, July 1957.

[3] Rambert, Madeleine L.: Children in conflict. Trans. by Yvette Moxley. International Universities Press, New York, 1949.

[4] Schwarz, Hedy: The mother in the consulting room: Notes on the psychoanalytic treatment of two young children. *In* The psychoanalytic study of the child, Vol. V. International Universities Press, New York, 1950.

[5] Bowlby, John: The study and reduction of group tensions in the family. *Human Relations*, April 1949.

It has been observed that the movements of the heavenly bodies since the beginning of time are not as complicated as the play of a child for a single hour.

D. A. Worcester in Exceptional Children, *September 1958.*

A case story of the growth of modern child-welfare concepts within an agency and a community.

FROM BOYS' RANCH TO CHILDREN'S SERVICES

DONALD W. JACKSON
Superintendent, Corsicana State Home, Corsicana, Tex.

INTENSIVE evaluation during the past 6 years by a children's institution in Harlingen, Tex., has led to the transformation not only of the institution but also of the community's conception of its children's needs. Beginning with a proposal for a fund-raising drive to enlarge the Valley Boys' Ranch, the combined study-action efforts of board, staff, and other members of the community resulted in the conversion of the "ranch" into a multiservice agency called the Valley Children's Services, serving both boys and girls through group care in small group homes, foster-family care, adoptive placements, and casework to parents.

Currently under consideration and study by the board of directors is a proposal to offer financial assistance in selected cases when it is economically sound and in the best interest of the children and family. The board is also considering the provision of homemaker service and marital counseling. The changes have come rather fast during the past 6 years, but slowly enough to be sound. The addition of these other services will necessarily come only after the present program is stabilized and the agency has sufficient casework staff, quantitatively and qualitatively, to handle them.

A full understanding of this development requires a brief review of the agency's 12-year history. It is perhaps fortunate that the agency is no older and was only 7 years old when a new executive director came in 1951. Tradition was therefore not a strong impediment to progress, although the board members' knowledge of practices in some older institutions occasionally stood in the way.

The agency was organized and chartered as Valley Boys' Ranch in December of 1945 to care for dependent and neglected boys. The idea for such a home originated in a local service club, through the instigation of a fund raiser who had helped to establish similar institutions over the State and offered to raise money for the purpose. His offer was accepted and a substantial sum of money was raised over a period of several months. A small house and 50 acres of land—untillable and full of gullies—were obtained just outside the city limits as a beginning.

Everything looked fine until the "help" settled up. The fund raiser had asked very little, it was thought, for his services—10 percent plus his expenses. However, when everything was tallied and his expenses plus 10 percent were taken out, little was left besides the house and grounds. There was not even enough money for the first year of operation. As a result the board members, with no knowledge of what is involved in operating a children's institution, assumed the actual operation of the agency, even to the point of taking turns living with the children.

In 1949 the institution was closed because of inadequate financing. The club which had been the original sponsor enlisted the aid of another service club, which in turn accepted sponsorship on a cooperative basis with all clubs of the same affiliation in a three-county area of the lower Rio Grande Valley—all within a 50-mile radius of Harlingen. With the aid of the entire Valley, the land at the ranch was leveled and underground irrigation was installed. In addition, a barracks building was obtained from

army surplus, moved on to the grounds, and completely remodeled by members of local labor unions and others. Materials and labor were all donated for the project, with hundreds of persons participating.

The board changed its membership when the new club took over, but not its function. For 6 more years it directly ran the agency, plagued always with rapid staff changes. Eventually the board decided to hire an experienced executive and to turn the operation of the agency over to him.

Important changes in board organization took place shortly after this. Originally each of the approximately 20 service clubs involved in sponsorship held two positions which were routine appointments with terms of one year each. One problem loomed immediately—it was possible to have a completely new board each year. Usually less than half the members were reappointed for another year, and many persons appointed to membership were not interested and did not attend meetings. Membership was confined to members of the service clubs.

Now board membership is open to men and women outside the service clubs and is the result of election by the board, rather than of appointment. Each sponsoring club is given an opportunity to submit names to a nominating committee, and one member from each club is usually elected to the board. Terms of office have been changed to 3 years, with one-third of the membership retiring each year. A member must be dropped for at least a year after serving two consecutive terms. Any board member who misses three consecutive meetings is automatically dropped. The board is widely representative of the occupations and the communities of the Rio Grande Valley. Nominees for membership are chosen on the basis of proven interest in work for young people, with consideration being given to occupational and geographical representation. Strong committees are now in operation and take an active part in policy setting, agency interpretation, and advising on agency problems.

Beginnings of Change

The change in the philosophy and program of the institution accompanied the change in the board structure and function. Back in 1952 and 1953, the board thought of the institution as providing permanent care for children and "the more the merrier!" In line with the Texan notion of "the bigger the better," a proposal was made to increase the facility to accommodate 1,000 boys, which somehow was to help the agency out of its financial difficulty. Numerous other proposals—including one for the boys to sell popcorn and peanuts on the street corners on Saturdays, with placards on their backs—revealed the complete lack of understanding of child-welfare concepts on the part of many board members and other influential members of the community.

After the arrival of the new executive it took about 6 months for the board and staff to reorganize and stabilize its program. In the light of the recommendations to increase the size of the institution, the staff, with the board's help, attempted, through an evaluation of agency potential and community need, to find out what type of child the agency could serve best. What they found were decided differences between *the child most people in the community thought should have institutional care, the child the agency seemed best able to care for, and the child who actually needed group care.*

The next step in determining which way the agency should move and in bringing the community along with it was a series of meetings attended by the executive and board of the agency, two district and juvenile judges, the supervisors of the county child-welfare units, the county probation officers, the area supervisor for the child-welfare division of the Texas department of public welfare, and the executives and representatives from the boards of directors of other local welfare agencies. The group agreed, on the basis of an actual count of boys known to them, on the need for a facility to care for 500 boys. In planning for action the figure was cut in half, a citizens' committee was formed, and preliminary plans were drawn for buildings. At this time, the average length of stay at Valley Boys' Ranch was approximately 5 years.

When the cost of achieving even this reduced plan became obvious, more doubt was raised regarding the need for such a large plant and for the kind of care the agency would be able to provide. The board, with staff leadership, then took a closer look at "the child who actually needs group care" rather than the one it was felt the institution could best serve. This resulted in the decision to change the agency's function and to improve services rather than to build buildings.

At that time what casework service was being given to the ranch boys and their families was being provided on a hit-or-miss basis by the county child-welfare units, which did not have adequate staff to do their own emergency work, let alone to work closely with the institution's children. After ap-

proximately a year of staff interpretation to the board of the need for casework services, the agency hired its own caseworker and initiated a social-services department. In this interpretation, case examples were used to explain how the constant change in caseworkers was damaging some of the children and increasing the length of their stay at the institution, and how, on the other hand, in some instances good casework was helping youngsters and decreasing their length of stay.

The staff also made a thorough study of the kinds of children the agency was accepting, the basis of accepting them, and the kind of planning that was being done for them. This brought about another review of all policies, resulting in changes in those regarding admission and discharge. As a result of these studies and interpretation, the board and the community began to recognize the difference in modern concepts of institutions and the children they can serve as compared with those of yesteryear.

Along with these studies the agency worked with other agencies to reach a clearer agreement about the kinds of children needing group care so that only such children would be referred and accepted for institutional placement. Psychological tests, complete physical examinations, and social histories, along with staff conferences with the caseworkers of referring agencies and with the children's parents, were made requirements for admission. All of these requirements helped in better planning for the children prior to their acceptance, provided the staff with a better understanding of each child, and generally put the agency on a more professional basis. Consultation with a local psychiatrist was eventually made available—a service which is presently being expanded.

In interpreting needs and services to the community the agency involved all of the other welfare agencies. This was necessary in order to develop an understanding of the function and responsibility of each agency in planning for the child, as well as in pointing out gaps in needed services. In these efforts some very effective help came from yearly licensing studies and evaluations being conducted by the child-welfare division of the State welfare department, which culminated in a study by the Child Welfare League of America. Each of these studies pointed out the institution's weaknesses as well as its strengths and helped sharpen the focus on the areas needing improvement. Responsible members of the community, drawn into the evaluations and well informed on the results, took pride in the institution's strengths, learned of changing needs in group care for children, and felt responsible for helping to improve the program.

The increase in the institution's services instead of in its housing facilities immediately began to show manifold results. After being licensed to do adoption and foster-home placements, the agency gradually became a multiservice agency, placing some of its children whose needs could best be met by family living into foster-family homes and some for adoption. The question of whether older children want and need adoptive parents or whether good adoptive couples can be found for older children has been answered by the fact that all adoptions achieved through the agency to date have been of boys 13 years of age or older.

The turnover of children in group care has drastically changed over the years, primarily as a result of increased services. The average stay has fallen from 5 years to 1 year. Therefore, without any additional buildings, the institution is serving more children than it did before the increase in services. Many of the children who previously would have come into the instiution either are being helped at home or in some cases are in foster-family care. Children at the institution who can no longer benefit from group living are being placed in foster or adoptive homes or, in most cases, are returning to their own homes as a result of closer work with parents. As these benefits became more obvious to the board and to the community, the results were closer and better community cooperation and increased interest.

Girls, Too

After a year of operation with the increased services, the agency could show that it was providing better services to children at less cost per child. This was an effective point against the expansion of group-care capacity when the question again arose, as it did at this time. Another series of meetings was held including essentially the same people who attended the series 2 years before—the juvenile judges, chief probation officers, child-welfare-unit director, child-welfare area supervisor, directors and board members of community welfare agencies dealing with children, and other interested citizens. The group looked at the service being provided in the light of community needs, with an obvious change in its basic philosophy regarding group care. It concluded that additional provision for group care was needed not for boys but rather for girls,

for whom no facility existed. Since the key to effective change had been community understanding of program and purpose, the agency decided to plan with the community for the creation of such facilities.

Accordingly, a meeting was called early in 1956 at the city hall in Harlingen, which is at the center of the Rio Grande Valley. The meeting was open to anyone who wished to attend. In addition to the original committee and representatives from the public welfare agencies, presidents of membership organizations and their welfare or youth-committee chairmen were especially encouraged to attend through letters outlining the purpose of the meeting. A panel to discuss the need included members of local agencies plus the consultant on juvenile delinquency of the Texas Youth Development Council.

Over 250 people representing more than 100 different organizations of 65 types in the Rio Grande Valley came to the meeting. Their response to the idea of providing group-care opportunities for girls was overwhelmingly positive, and a steering committee was nominated and elected on the spot. Committees were formed soon afterward to cover financing, public relations, and buildings and grounds.

The ***finance committee*** obtained pledges and cash contributions on a regular basis to support the new institution, gained its admittance to local United Funds, and established a cash reserve for the first year of operation with assurances of continuing financial support.

The ***public relations committee*** took responsibility for continuously publicizing through newspapers, television, and radio the need for a group home for girls and the kind of facility needed. Through these media and a schedule of talks and discussions with various service groups, the home soon became a Valley-wide project on the bases both of interest and support.

The ***building and grounds committee*** obtained the contribution of services of an architect, an interior decorator, and all the local labor unions, whose members donated their labor to construct the residence. It also secured a donation of land and, through a local foundation, a substantial cash contribution to buy materials. Many materials were also secured as donations. The furniture was given by various individuals and service clubs in addition to their cash contributions. Incidentally, with the exception of an inconspicuous cornerstone crediting the labor unions, there are no signs or plaques on the residence indicating the donors of anything or otherwise identifying the place as an institutional home for girls.

Special committees worked on special projects in cooperation with the three main committees. During the first year all committees were assisted by the regular standing committees of the agency and coordinated through the executive committee of the agency's board of directors. At the end of the year the committees were absorbed as part of the agency's standing committees or dissolved, with the exception of the building committee which continued to function until the residence was completed.

Developing Understanding

A special subcommittee of the building and grounds committee selected the residence's location. The size and location of the home today reflect the growth in this committee's understanding of the needs of children under care and of its ability to pass this understanding on to the community through the organizations its members represented and through the public-relations committee. Through this subcommittee's discussions and activities, the community soon began to recognize that the children the group home would be serving would need the same kinds of things that all children need plus a great deal more—the "more" being a larger measure of understanding to make up for the dearth of this in their earlier lives—to be provided through a warm, interested houseparent, skilled professional staff including social caseworkers, psychologist, and psychiatrist, and a program and living arrangements designed to fullfill their needs. The committee recognized that the "plus" phase would have to be left up to the administration, and saw its task as the fulfilling of needs which these children have in common with all children.

Recognizing that children living away from home already feel different from other children because they are not with their own parents, the committee saw the importance of avoiding the many unnecessary appurtenances of institutional life which constantly remind institutionalized children of their singularity. It came to see that the children in the new group home would need the same acceptance in the community as other children; and that to locate the home away from the community would make it difficult for its children to participate in community activities, and so to feel accepted. Nobody on the committee wanted the children to feel rejected and pushed out by the community. As the importance of location to the avoidance or promotion of this feeling became clear through many committee dis-

cussions, the decision was reached to locate the home in a residential area near schools and churches. The land obtained was in such a location, with an elementary school, junior and senior high schools, and several churches within walking distance.

In considering the size of the residence, the committee came to the conclusion that the girls needed a home that looked like any other home in the particular residential area; that they should not feel different from the girl next door because of the appearance of their house. A local architect with a national reputation contributed his services. A residence to accommodate eight girls was designed in such a way that in the future, if desired, it could be turned into a regular residence with the minimum of effort and cost.

The house includes, in addition to the common rooms, a room for the housekeeper, one for the relief housekeeper—which doubles as a guest room—and two large bedrooms for the girls, each designed to accommodate four girls. The capacity was set at eight girls, with the purpose of making the home large enough to provide group living for girls needing an impersonal atmosphere, yet small enough for those girls able and willing to accept close family living.

The actual use of the girls' group home can easily change as need changes. It allows for more flexibility by far than the old-type institution. Increase and decrease in the size of the facility can take place without affecting other parts of the agency's total program. Increase in facility can be accomplished in stages not requiring the immediate financial support that large plants must have for maintenance and staffing. Cost per child, even though in a smaller group and a more normal setting, is proving to be less than in the larger institution for boys, and the agency is providing the girls with better care.

Plans are now drawn for the construction of a group home for boys to replace the present remodeled barracks building, which houses 20 boys. It will be constructed on the present site of Valley Boys' Ranch, for much of the ground here is soon to be turned into a residential subdivision. This is within the city limits of Harlingen and is conveniently located. The new boys' home will hold 10 or 12 boys, with an additional part-time staff member available to work with boys interested in farming and in 4-H projects.

There is a possibility that additional group homes will be established in adjoining communities as the need becomes evident. They will be under the central administration of Valley Children's Services. Consideration also is being given to designing the next group home to care for both boys and girls so that brothers and sisters may be kept together.

Since the present site of Valley Boys' Ranch is within the city limits, consideration is also being given for a small group facility to be located outside the city limits, but easily accessible to the community. The program would be designed to provide an opportunity for experience in agricultural activities, including work with livestock and citrus farming, for boys who need it.

The flexibility of the group-home design provides innumerable possibilities for outstripping old-type institutions, whether of congregate or cottage-plan variety, in meeting children's needs.

The girls' residence officially opened in February 1958—two years after the initial Valley-wide meeting. It took a long time, but the patient inquiry and interpretation have produced results. Almost everyone in the community feels as though he had had a part in creating the new facility. And, even more important, both the community at large and the board and staff of the Valley Children's Services have a better understanding of the kinds of services children in the Valley need.

We have all become people according to the measure in which we have loved people and have had occasion for loving. . . . To love selflessly and unconditionally, with a strength equal to the square root of distance, is the task of our hearts while we are children.

Boris Pasternak in Safe Conduct: Autobiography *as published in* Boris Pasternak: Selected Writings, *New Directions, 1949.*

HERE AND THERE

Conference on Adoption Research

In response to expressions of interest in learning about the outcome of adoptive placements, the Elizabeth McCormick Memorial Fund held a 2-day meeting, November 13-14, to consider a possible design for a followup study in adoption. Of the 15 participants (coming from Eastern, Midwestern, and Western States and from Canada), 9 were primarily research-oriented and 6 primarily involved with agency administration and practice. Each participant submitted in advance a study proposal and these were circulated before the meetings.

In a series of spirited sessions, the group reached relative consensus on a number of points and clearly defined disagreements on some others. It was generally agreed that we need to think of multiple approaches and to plan for research programs rather than discrete projects. That is, instead of one grandiose project, the participants favored many separate studies under varied auspices, each study fitting into a broad, general plan.

Three general types of study were pointed out as feasible and urgent: the longitudinal, beginning with current adoption cases and following them through a period of time, with repeated investigations at stipulated periods; a study using a "cross-sectional approach" which would examine the current status of adoptions completed 5, 10, and even 15 or more years ago; and a wide variety of "tooling-up" studies designed to identify the variables and develop the methods requisite to satisfactory adoption research.

During the two days specific plans were made for work in two of these categories and further activity in the third—one plan being for a cross-sectional study in which three of the agencies represented at the conference would collaborate. The need for such collaborative effort was among the salient points of discussion and resulted in a recommendation for greater pooling of research activities and resources, including exchange of data.

A recurring point concerning the practice of child-placing agencies was the question of whether less emphasis should be placed on screening applicants and more on helping them to develop their full potentialities as adoptive parents. Several members of the group reported that a trend in this direction is perceptible in current practice. According to their reports some agencies are accomplishing the main selection in the initial interview and devoting the chief attention in subsequent interviews to education for adoptive parenthood. This shift of emphasis, it was pointed out, is clearly related to the intake situation of the individual agency; and also, perhaps, to changes in the always-evolving conception of the child-placing agency's functions.

Mental Retardation

An intensive survey of the research on mental retardation being done in southern States will be completed early in 1959 by the Southern Regional Education Board. The information is being collected to show not only the content of the research but the fiscal, administrative, and other provisions made for this work in the 16 States the board covers. The survey is part of a larger one on mental-health and behavioral-science research in the southern region, being undertaken as part of the board's mental-health program.

The board is also surveying the needs of the region for personnel in the field of mental retardation.

Among the other activities of the board in relation to mental retardation are: sponsorship of a series of research conferences, each bringing together five or six workers engaged in similar research to discuss common problems; helping the States in the southern region to recruit and train teachers for the retarded and to pool resources in developing centers for the doctoral training of such teachers; administration of a grant from the National Institute of Mental Health to enable personnel of institutions for the mentally ill and the mentally retarded in the southern region to study at similar facilities in other States.

The board was established in 1949 under interstate compact to aid the States represented on it to share their college and university resources.

. . .

In an effort to shed some light on the question of whether mentally retarded children with no known organic feature to explain their condition are retarded because of genetically or environmentally determined factors, a longitudinal, interdisciplinary study of 15 such children is under way at the child-development clinic of the State University of Iowa. It has two aims: (1) to amass and integrate medical, psychological, educational, and social information about the children, gathered over a period of 5 years, into a meaningful whole; and (2) to see if a concentrated effort to meet every aspect of these children's needs—medical, nutritional, educational, psychological, and social—can mitigate their symptom of retardation.

The project provides all these services directly, using an experimental nursery school especially established for the purpose as a device for increasing learning deficits, giving the children a social experience, and, through school lunches, improving their nutritional opportunities. In addition it offers psychiatric, social-casework, and home-management help to those of the children's parents who seem to need it.

All the children in the study come from families low in the socio-economic scale. A group of similar children in another city, to receive the project's tests but none of its services, has been selected as a study control.

Collaborating in the study are specialists in psychology, pediatrics, neurology, psychiatry, social work, education, and nursing from the university's various schools and departments and from its Child Welfare Research Station.

. . .

Severely retarded children receiving classroom instruction in a 2-year experimental training program in seven pub-

lic-school classes and 10 institution classes did not improve beyond the normal growth indicated by their intelligence quotients, according to the results of a study recently completed for the New York State Interdepartmental Health Resources Board. The investigators concluded that the solution of the main problem of those children, whose I. Q.'s ranged from 25 to 50, should be sought in "life planning"—training for self-care and maximum socialization—rather than in classroom instruction. The investigators noted that their findings with these children contrast markedly with findings in respect to less severely retarded children

Homemaker Service

Homemaker service has become a major specialized service of the child-welfare unit in Hidalgo County, Tex., where nearly one-sixth of all the children served during the year which ended June 30, 1958—or 116 of a total of 756 children—received care from homemakers sent in to help the family in times of the mother's absence or incapacity. This homemaker service continues to grow. Three new homemakers were added to staff between September and November 1958, bringing the total of full-time homemakers to 15.

In an inservice training program for the homemakers, the unit has called in the county home-demonstration agent county public-health nurses to lead discussions on: budgeting for low-income families; meal planning for low-income families; child care in the homes with little or no facilities; first aid and its uses. The Norwegian film "Emergency Housewife" has been used as a visual aid in helping them to understand their part in keeping families together.

. . .

An agency to provide homemaker service has just been developed in the State of Israel through cooperative effort and sharing of administrative costs by several voluntary organizations and the Ministries of Health and Social Welfare. The new agency will operate on a fee-for-service basis, payment being made by the referring agency or by the families themselves, who may apply directly for service.

. . .

The film "Home Again" produced by the Mental Health Film Board to interpret homemaker services to the public is also being used by some agencies in in-service training of their homemaker staff. In Cleveland the Family Service Association and the Jewish Family Service Association recently provoked lively discussion at a showing of the film to their homemakers by dividing them in groups, each group being assigned to notice particularly the feelings of father, mother, or children in the story's family. The 16-millimeter film may be purchased from the Mental Health Film Board, 267 West 25 Street, New York 1 (price $145), or borrowed or rented from State or local mental-health societies, public libraries, or educational film libraries.

The National Conference on Homemaker Services is to be held in Chicago on February 10 and 11 (not February 11–12 as reported in the last issue of CHILDREN), with Mrs. R. Livingston Ireland as its chairman. The conference is being sponsored by 8 units of the Department of Health, Education, and Welfare and 26 national voluntary agencies. Co-chairmen of the executive committee are Katherine B. Oettinger, chief of the Children's Bureau, and Clark W. Blackburn, general director of the Family Service Association of America.

Immediately after the conference, the National Committee on Homemaker Service will hold a one-day meeting to plan continuing activities in line with the conference's suggestions.

Health Research

Groundwork for stimulating new research on the effects of tranquilizers and other drugs on children is being laid by the Psychopharmacology Service Center of the National Institute of Mental Health, which plans to support such research through financial grants. An initial step in this direction was an all-day conference held under the center's auspices in Washington in mid-October at which clinical and laboratory psychologists, pediatricians, psychiatrists, social workers, and neuropharmacologists identified problems in the use of drugs by children and suggested ways of solving them through research.

Under deliberation were such questions as how drug effects on children can be accurately measured, how to determine whether the drugs can be safely given to children for long periods of time, and how to determine whether the drugs affect children's learning ability and other aspects of their development. The conferees also discussed the question of whether some of the research techniques used to study drug effects on laboratory animals can be adapted to use with children.

The Psychopharmacology Service Center's interest in this type of research as part of its broad program of research on drugs used in psychiatric treatment—their clinical effectiveness, their liabilities, and their basic mechanisms of action—encompasses the effects of the drugs on normal as well as on emotionally disturbed and retarded children.

. . .

At the suggestion of the National Institute of Allergy and Infectious Diseases, the Children's Bureau and the National Office of Vital Statistics have initiated a joint project to obtain information relating to the incidence of cystic fibrosis of the pancreas among children.

The disorder is a rather recently recognized familial disease that manifests itself in infancy and early childhood. A pancreatic defect causes intestinal indigestion resulting in malnutrition and retarded growth. Repeated respiratory infections of increasing severity are characteristic and, before antibiotics, were a common immediate cause of early fatality. Progress has been made in diagnosis and treatment but the basic defect is not yet understood. Its incidence is not known; an estimate based on limited 1945–49 data is that it may occur 7–10 times per 10,000 live births.

Since most children suffering from this condition are believed to be hospitalized, the study will be conducted by means of questionnaires to hospitals. A preliminary inquiry to obtain gross data will be followed by a case survey to refine the data and obtain additional information on the epidemiological aspects of the disease.

Child Welfare

For 2 days in early October the State public welfare administrators and child-welfare directors met with the Children's Bureau in Washington, the first such conference in 14 years, to discuss ways in which the Bureau and the States can together promote progressive child-welfare programs.

The first day was spent in considering material prepared by the Bureau

on procedures for implementing the 1958 amendments to title V, part 3, of the Social Security Act. (See CHILDREN, November-December 1958, p. 231.) State representatives exchanged information on ways in which they are now using Federal child-welfare services funds.

On the second day there were group discussions of questions on organization, administration, and training for child welfare; strengthening services to children in their own homes and in foster care; and the role of the State public welfare agency in providing juvenile-delinquency services.

Among the recommendations which came out of the group meetings were: a request for similar conferences, to be held more frequently, not only in Washington but elsewhere on a regional basis; increased help from the Children's Bureau in such areas as administration and organization; help from the Children's Bureau and the Bureau of Public Assistance in achieving better coordination in State and local programs for families and children.

. . .

In the 23 months between September 1956 and August 1958, the adoption resource exchange operated by the Texas State Department of Public Welfare was used in the placements of 234 children in 146 adoptive homes. The exchange, established by the department's child welfare division in September 1949, has been used not only by the department's 20 child-welfare units, but also, through less frequently, by voluntary agencies in the State. (See "Placing the Older Child in Adoption," by Anne Leatherman, CHILDREN, May-June 1957, p. 107.)

Besides the children placed singly, the exchange helped in finding homes for a number of brothers and sisters together. One couple took 6 children ranging in age from 3 to 13 years; 4 couples took 5 children each; 4 took 4 children each; 5 took 3 children; and 37 couples took 2 children each.

Twenty-eight percent of the children were 6 years of age or older at the time of placement; 33 percent were between the ages of 2 and 5; and 38 percent were under 2 years of age.

Twenty-seven of the children had physical handicaps. These included not only minor orthopedic conditions, but also cardiac disorders, deafness, and blindness.

Eighty-four of the children were of minority ethnic origin: 26 were Negroes; 46, Latin American; and 12, mixed Latin-American and Anglo-American.

Youth and Parents

Young people and their parents from 67 counties in Pennsylvania gathered together in Harrisburg, the State capital, last September, in a conference called by the Governor, to discuss the opportunities and responsibilities of youth today and to participate in the State's preliminary planning for the 1960 White House Conference on Children and Youth. Most of them came prepared by discussions at home and at school of a number of questions sent to them by the Governor's Committee on Children and Youth, sponsor of the conference. These were grouped under the 3 subjects of the 12 conference workshops: student morale and responsibility; post high-school opportunities; and job opportunity and availability.

Representatives from 16 statewide or regional organizations concerned with youth and 16 young people between the ages of 16 and 20 composed a group of advisers to the Governor's committee in planning the conference. The participants in the conference, all invited as individuals, included persons of various races, religions, interests, economic and environmental backgrounds, and educational and vocational plans. In the discussions many of the young people expressed a strong desire to be given responsibility both inside and outside the home and as one 17-year-old put it, "to be given a chance to really contribute something to the world if we can."

White House Conference

The first meeting of the National Committee of the 1960 White House Conference on Children and Youth took place December 16–18 in Washington on call of President Eisenhower, the committee's honorary chairman. The President received the committee at the White House on the first day of the meeting.

The committee adopted the following theme:

"The purpose of the 1960 White House Conference is to promote opportunities for children and youth, to realize their full potential for a creative life in freedom and dignity.

"This effort will be based on: (1) study and understanding of the values and ideals of our society; the effect on the development of children and youth of the rapid changes in this country and the world; and how families, religion, government, community services—such as education, health, and welfare—peer groups, and the behavior of adults in their interactions with children and youth deter or enable individual fulfillment and constructive service to humanity.

"(2) Examination of the degree of achievement of previous White House Conferences' goals and recommendations.

"(3) Determination of the action that individuals, organizations, and all levels of government can take to implement Conference purposes".

Included on the widely representative 92-member committee, appointed by the President in early November, are 9 young people of high-school or college age, selected for their leadership in school, church, and community youth activities. The committee's chairman is Mrs. Rollin Brown, immediate past president of the National Congress of Parents and Teachers. The Secretary of Health, Education, and Welfare, Arthur S. Flemming, is honorary vice-chairman; and the Chief of the Children's Bureau, Katherine B. Oettinger, is secretary.

The vice-chairmen are: Dr. Hurst Anderson, president, American University; Dr. Philip S. Barba, former president, American Academy of Pediatrics; Mrs. James Blue, president, National Association of Governing Boards of State Universities and Allied Institutions; Robert E. Bondy, chairman of the Council of National Organizations; Erwin D. Canham, editor, Christian Science Monitor; Donald K. David, chairman, executive committee, Ford Foundation; Dr. Luther Foster, president, Tuskegee Institute; Monsignor Raymond J. Gallagher, assistant director, Catholic Charities, Diocese of Cleveland; Mrs. Frank Gannett, chairman of board, Gannett Newspaperboy Scholarships; Dr. Edward D. Greenwood, coordinator of training in child psychiatry, Menninger Foundation; Dr. Daryl P. Harvey, staff physician, Howard Clinic, Glasgow, Ky.; Donald S. Howard, chairman, National Council of State Committees for Children and Youth; Ruth Stout, president, National Education Association; Rabbi Marc H.

Tanenbaum, executive director, Synagogue Council of America; Rev. William J. Villaume, executive director, department of social welfare, National Council of Churches.

Each member of the committee serves as an individual and not as an organizational representative.

. . .

The *Conference Reporter*, a newsletter on activities in preparation for the 1960 White House Conference, made its first appearance in November. It is issued by the Conference staff.

Honored

For her work in creating "a coherent public-health program out of the beginnings of the child-health movement in this country" Dr. Martha M. Eliot, former chief of the Children's Bureau and now professor of maternal and child health at Harvard School of Public Health, received the Sedgwick Memorial Award, highest honor annually bestowed by the American Public Health Association, at the association's 1958 meeting in late October.

The citation, read by Dr. Leona Baumgartner, Commissioner of Health of New York City, not only praised Dr. Eliot's leadership in the Children's Bureau's efforts "to bring the fruits of new medical knowledge promptly to the people and to promote a higher quality of medical service for them," but also mentioned her previous research studies at Yale and her work with UNICEF and with the APHA itself as past president and active committee member. "All of her work," it said, "seems to spring from a deep understanding of two closely interwoven concepts—the child as an individual and children in and of a community."

Infant Care

At the White House in mid-October, the President of the United States presented the 40-millionth copy of the Children's Bureau publication, *Infant Care*, to a young couple from Carbondale, Ill., Mr. and Mrs. Jerry E. Levelsmier, selected by the Children's Bureau with the help of their State and county health departments as representative American parents. The event received national publicity through press, radio, and television. Mr. and Mrs. Levelsmier were already acquainted with the publication, having used it as a guide in the early care of their two children, now aged 4 and 2.

BOOK NOTES

COLLECTED PAPERS; through paediatrics to psycho-analysis. D. W. Winnicott. Basic Books, New York. 1958. 350 pp. $6.50.

The three groups into which the 26 papers collected in this book are divided represent three phases in the professional life of the author, who is a British pediatrician and psychoanalyst. The papers in the first group, he explains, represent his attitude as a pediatrician before beginning training in psychoanalysis. Those in the second were written after he became psychoanalytically oriented, and those in the third constitute a personal contribution to current psychoanalytic theory and practice.

The 2 papers in the first section discuss anxiety as a normal characteristic of childhood, and children's fidgetiness, tics, and chorea; the 8 in the second group, such subjects as appetite and emotional disorder, the child's eyes in relation to psychoneurosis, and anxiety associated with insecurity. Among the 16 subjects discussed in the third section of the book are primitive emotional development, aggression in relation to emotional development, withdrawal and regression, and "the antisocial tendency."

Maintaining that pediatrics is too fully occupied with the physical, the author urges younger colleagues to take psychoanalytic training and to modify what they learn to fit individual cases.

NUTRITION AND THE PAPUAN CHILD; a study in human welfare. By H. A. P. C. Oomen and S. H. Malcolm. Technical Paper No. 118. South Pacific Commission, Nouméa, New Caledonia. 1958. 146 pp. $1.20.

This report is based on studies carried out by a physician-nutritionist and a dietitian-nutritionist in selected areas of Australian New Guinea and Netherlands New Guinea. Beginning with a survey of the nutrition and diet of mothers and their young children, the authors proceeded to study the character and availability of the food resources of the general population, and finally to consider the total subsistance economy of the areas.

The last chapter before the summary deals with prospects for improvement. The authors state that in the Papuan villages "the child and the mother are at the very roots of human welfare." In their opinion, "It would seem wise, before the development of New Guinea 'at an accelerated pace' is considered, to be concerned about food requirements and body-building substances; and about the heart of the community life, that is, the mother-child relationship."

GROWING FROM INFANCY TO ADULTHOOD; a summary of the changing characteristics of children and youth. Edward C. Britton and J. Merritt Winans. Appleton-Century-Crofts, New York. 1958. 118 pp. $1.10.

One of a series on current problems in education, this book summarizes typical patterns of behavior of children and young people through the age of 20. Appendices give percentiles for weight and height of American children from birth to 18 years of age; chronology of pubertal developments in height, weight, and sex characteristics; lists of materials on child development; textbooks; reports of research; and other books, pamphlets, journals, and films.

The book is addressed to a wide range of readers, including parents; teachers, leaders, and administrators in schools and community agencies; students; and children and youth, to whom, the authors say, "the book gives insights into their own behavior otherwise not ordinarily obtainable."

READERS' EXCHANGE

McFERRAN: ***A question of when***

I have read with a great deal of interest Jane McFerran's description of the imaginative use of the group process by the protective service division of the Jefferson County Welfare Department in helping parents who neglect or abuse their children. ("Parents' Groups in Protective Services," by Jane McFerran, CHILDREN, November-December 1958.)

It appears that the experience of the parents in being involved in a group with other parents having similar problems was a constructive one. The parents were presumably able to carry over added strength in individual casework treatment with their worker as a result of the group meetings.

I would like to raise the question at what point in the casework process of individual help to these parents the group experience was introduced? This is not entirely clear from the article. Parents who neglect or abuse their children suffer from seriously underdeveloped and damaged image of self. In the individual helping process, results come from beginning where the person is, and, through the worker, supplying the adequate parent figure with whom the parent can relate. This is essential to his moving on to a broader identification with neighbors, friends, and eventually the community.

My question is this: is the child, who is in this case the parent, able to relate to nursery school or school, which is in this situation a group experience, before he has sufficient time to receive the necessary ego support from the parent figure, in this case the individual caseworker? Careful timing is of utmost importance.

Most of the parents that we see in our protective program in Missouri ("Protective Casework Service," by Lorena Scherer, CHILDREN, January-February 1956) need a period of working out a purposeful relation with one individual, the caseworker, before they are ready to relate purposefully to others. The relationship to the caseworker is meaningful to the parent as parental-substitute identification and has a bearing on his own expectation for progress. Most of the parents need considerable individual understanding before change takes place. I am surprised that such depth of understanding was forthcoming from other parents who were likewise deprived.

It is only through actual experiences with processes such as Mrs. McFerran describes that we will move forward in this area.

Lorena Scherer
Child Welfare Supervisor, Missouri State Department of Public Health and Welfare.

HERZOG: ***Application re adoptions***

Elizabeth Herzog has performed a very useful service in pointing up the key issues that must be faced by those who eagerly seek rather definitive answers to questions concerning the effectiveness of services aimed at producing changes in the social and psychological functioning of individuals. ("How Much Are They Helped?" by Elizabeth Herzog, CHILDREN, November-December 1958.)

Her comments apply equally well to other areas of service to individuals and families. For instance, there is a strong desire in many quarters to find answers to such questions as: How do adopted children turn out? Have agencies used good judgment in choosing among adoptive applicants? Is foster care all that its enthusiasts say it is?

Miss Herzog's distinctions between *ultimate evaluation*, *pre-evaluative research*, and *short-term evaluation* and her listing of the various task requirements associated with these categories usefully delineates research undertakings for agencies to consider carefully. For the agency without full-time research staff, the last-named type of research seems most feasible and can be extremely helpful in preparing the groundwork for research at the preceding two levels.

It is a fact that the development of useful typologies in child-welfare research has been greatly hampered because the simple phenomenology of agency programs has not been systematically recorded. It is important to know even gross characteristics of the following types of situations: (1) unmarried mothers who keep their babies as opposed to those who relinquish theirs for adoption; (2) children who remain in foster care as opposed to those who move on to adoption; (3) adoptive applicants who are approved by agencies as opposed to those who are not.

In obtaining such gross data and subjecting it to fairly simple analysis, agencies will be shedding light upon their own programs as well as preparing the groundwork for those researchers who are in a position to devote full-time effort to research of a more complex nature. In doing this necessary preliminary work, I would like to underscore Miss Herzog's plea that agencies not be afraid of doing unpretentious work. To quote Fielding: "Thy modesty is a candle to thy merit."

David Fanshel
Director of Research, Child Welfare League of America.

RABIN: ***Adjusted to what?***

Dr. Rabin's interesting report on child rearing in the collective settlements of Israel discusses social adjustment in such a way as to bring into the picture that to which adjustment is supposed to be made. ("Kibbutz Children—Research Findings to Date," by Albert I. Rabin, CHILDREN, September-October 1958.) In his last paragraph, he indicates that all evaluations of the adequacy of child-rearing methods should be made with reference to the society in which the children are to function.

This reasonable proposal raises the question of how to judge the adequacy of child rearing in terms of cultural values not one's own. Actually, Dr. Rabin makes his judgments regarding "adjustment," "maturity," and the like in terms of our society, not that of the kibbutz. Thus, in an earlier article in the *Journal of Projective Techniques* (June 1957) he reports on a variety of techniques for judging adjustment and maturity through Rorschach findings, using standards and "signs" that have been developed far away from the kibbutz culture. Moreover, in no place does he mention those kibbutzim that

have given up the communal method of child rearing.

Which methods are better for the kibbutz culture? These considerations suggest that a historical perspective may be helpful, both for inquiring into the actual aims of those who founded the kibbutzim and for verifying the extent to which the kibbutz-reared youngsters may have realized, perpetuated, or transformed these values.

That part of Dr. Rabin's research which deals with the older groups—the 9 to 11's as well as the 17-year-olds—raises the most troublesome problems. Dr. Rabin judges the kibbutz youngsters to be "superior" to his control group, but I would worry about some of the kibbutz characteristics on which this judgment is based. Most striking, here, is the apparent preoccupation of many kibbutz adolescents with such "altruistic" goals as world peace. This kind of impersonal affect, at a time when a more personal orientation is expected in our culture, considered in conjunction with the more diffuse personal identifications which Dr. Rabin documents, suggests a certain emotional blandness and possibly impoverishment.

It seems that one of the most challenging problems which Dr. Rabin raises—what happens to the kibbutz youngster that turns his inferiority as an infant into a superiority as an adolescent—may well turn out not to be a problem at all. The emotional deprivation in infancy which Dr. Rabin so ably discusses may very well still be hidden underneath those oversocial responses in adolescence.

Werner Cohn
Head, Department of Sociology, Northland College, Ashland, Wis.

BRIM: ***Parent education***

Orville Brim correctly calls attention to the multiplicity of factors which influence the effectiveness of parent education. ("The Sources of Parent Behavior," by Orville G. Brim, Jr., CHILDREN, November–December 1958.)

He discusses the conscious factors in a single paragraph, however, and then gets to work on the unconscious factors. I would not have dismissed the conscious factors so lightly, for I am one who believes the unfortunate conventional analogy of the iceberg should be reinterpreted so that the part of the "berg" which is in the air represents the unconscious, and the seven-eighths that is in good, touchable water represents the conscious. Many young parents these days express a willingness to learn, even an anxiousness to have information on parenting. They often say, "I had no brothers or sisters and I have never been around a baby; I need all the help I can get." This may fairly be considered a conscious motivation.

However, assuming the unconscious factors to be large, why not consider them proper foci for parent education? The speed with which people now recognize rationalizations seems greater than it once was. Maybe we can teach parents about subliminal struggles for dominance, love-hate, sibling rivalry, high and low masculine and feminine indices, and the like. One by one we may be able to lift these unconscious motives by a sort of mass educational psychoanalysis to the point where, seeing them, parents will be less influenced by them.

True, unconscious factors inhibit all learning in all areas to some extent; but educators, generally, do not allow such factors to stop them in their efforts. Sometimes, too, these factors enhance learning.

Dr. Brim does not call attention to variations in the power of the forces that seem to play upon the parent because of the time factor. No doubt the parent is more educable at certain times than at others. It is not too soon to start parent education before people marry, or at least before the first baby is born. It also seems that there is a period during the first months of the life of the first child when parents are more teachable. After there are several, or even just two, children in the family the patterns of child care probably become pretty well set.

The possibility of learning is also indicated by the general presence in our culture of the idea that our own parents are old-fashioned in most ways, including their methods of child care. Change is considered desirable. There is also in our culture the belief that science is changing all things and affecting all phases of our lives—even to the rearing of children. We should take advantage of these points of view, correct or not, in parent education, if we can.

Moreover, ideas tending to neutralize good teachings are constantly being fed to parents by unsavory sources. Thus we must teach, and re-teach.

Loyd W. Rowland
Executive Director, Louisiana Association for Mental Health, New Orleans.

PERKINS: ***Priority for mental health***

In reading Dr. Perkins' excellent article on school-health programs ("Improving the Health of Children of School Age," by Georgia B. Perkins, CHILDREN, September–October 1958), I could not but wish that she had presented a number of concrete suggestions about some organized way to reach solutions to our predicament.

Truly we are paying a heavy price for specialization in medical as well as in school circles. The ability to communicate seems to be in inverse ratio to our degree of specialization. Knowledge in science and education is leaping over hurdles, previously formidable, and yet understanding in the interests of boys and girls creeps along at a snail-like pace. Physicians, parents, teachers, and all social agencies serving children within any community have vast resources in each instance, but we have not found a way to communicate effectively in the interests of our principal reason for being—our children. Perhaps a community health, physical, and mental council representing all of these interests could do much to connect data, define problems, establish priorities, and develop the educational programs necessary to utilize specialized knowledge through communication.

Teaching information about health is a relatively simple matter. Developing healthy attitudes toward one's body, one's self, and other people, including loved ones, is more difficult. Although Dr. Perkins puts some emphasis in the article on mental health, this aspect of health must be given a much higher priority in the values attributed to a health program.

O. M. Chute
Superintendent, Community Consolidated Schools of Evanston, Ill.

Photo Credits

Frontispiece, Esther Bubley.
Page 6, San Jose Field Relocation Office, Bureau of Indian Affairs.
Page 21, Department of Welfare, Wake County, N. C.